

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, October 9, 2013 at the hour of 9:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Directors Wayne M. Lerner, DPH, FACHE, and Luis Muñoz, MD, MPH (3)

Director Hon. Jerry Butler

Absent: None (0)

Additional attendees and/or presenters were:

Krishna Das, MD – System Director of Quality,
Patient Safety, Regulatory and Accreditation

Randolph Johnston – System Associate General
Counsel

Linda Rae Murray, MD – Cook County Department
of Public Health

Elizabeth Reidy – System General Counsel

Tanda Russell – Interim Executive Director of
Nursing

Deborah Santana – Secretary to the Board

John Jay Shannon, MD – Chief of Clinical
Integration

Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of
Cook County

II. Public Speakers

Chairman Collens asked the Secretary to call upon the registered speakers.

The Secretary called upon the following public speaker:

1. George Blakemore Concerned Citizen

III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation

A. Update on Culture of Safety Survey Results (Attachment #1)

Dr. Krishna Das, System Director of Quality, Patient Safety, Regulatory and Accreditation, provided an overview of the information presented regarding the Culture of Safety Survey results. The Committee reviewed and discussed the information.

Director Lerner thanked Dr. Das and the staff for the exceptional reports that have been provided to the Committee. He noted that the strategic issue is really the issue of the culture - not a culture focusing on safety, but a culture focusing on trust. This needs to be embedded in an overall human resource plan that deals with the interaction between front-line managers and supervisors and their direct staff, because the supervisors are seen as the representatives of management. He inquired whether there is a human resource policy or effort underway that will encapsulate this element. Dr. Das responded that there does need to be a human resources policy addressing this; that subject has been under discussion, and will probably take some time to build because the System has a very established infrastructure. Director Lerner stated that he hopes to receive a report sometime in the future that reflects the three parties involved – front-line managers and supervisors, direct staff, and labor – and how they are working towards the effort of a culture focusing on trust.

IV. Action Items

A. Minutes of the Quality and Patient Safety Committee Meeting, September 23, 2013

Director Lerner, seconded by Director Muñoz, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of September 23, 2013. THE MOTION CARRIED UNANIMOUSLY.

B. **Medical Staff Appointments/Re-appointments/Changes** (Attachment #2)**

Director Muñoz, seconded by Director Lerner, moved to approve the Medical Staff Appointments/Reappointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections IV, V and VI

V. Recommendations, Discussion/Information Items

A. Report from the Cook County Department of Public Health (CCDPH) (Attachment #3)

i. Updates on the following:

- **Public Health Accreditation Board (PHAB)**
- **2015 Strategic Plan**
- **Quality Activities**

ii. Receive the following policy briefs:

- **Obesity Brief**
- **Physical Activity Brief**
- **School Meals Brief**

iii. Receive and file the following reports:

- **Annual Tuberculosis Surveillance Report, 2012**
- **Sexually Transmitted Infections Surveillance Report, 2011**

Dr. Linda Rae Murray, Chief Medical Officer of CCDPH, provided an overview of the information and reports presented. The Committee reviewed and discussed the information.

During the review of the information, Director Muñoz inquired regarding emergency planning. Dr. Murray stated that emergency planning is a big, relatively well-funded area. County government has a structure headed by Michael Masters, with whom CCDPH interacts; with regard to suburban Cook County, one of CCDPH's tasks is to work with the nearly two hundred fifty (250) villages and towns and coordinate the work. Following the discussion of the subject, Dr. Murray stated that this Committee can request to look at emergency planning in more detail; she stated that representatives from the City of Chicago can also be brought in for a more comprehensive report on the subject.

Director Lerner, seconded by Chairman Collens, moved to receive and file the Annual Tuberculosis Surveillance Report of 2012 and the Sexually Transmitted Infections Surveillance Report of 2011. THE MOTION CARRIED UNANIMOUSLY.

V. Recommendations, Discussion/Information Items (continued)

B. Reports from the Medical Staff Executive Committees

- i. Provident Hospital of Cook County**
- ii. John H. Stroger, Jr. Hospital of Cook County**

The report from Dr. Pierre Wakim, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County, was deferred to the Committee's meeting in October.

Dr. Ozuru Ukoha, President of the EMS of John H. Stroger, Jr. Hospital of Cook County, presented his report on the following subjects that were discussed at the recent EMS meeting: information technology / password change update; residency training; medical staff appointments/reappointments/changes; and site visit to the Burn Unit by the American Burn Association.

In response to a question from Dr. Ukoha regarding subjects of interest to include in the reports from EMS, Chairman Collens stated that future reports should focus more on actions to improve patient safety and quality.

VI. Closed Session Items

- A. **Medical Staff Appointments/Re-appointments/Changes**
- B. Litigation Matter(s)**

The Committee did not recess the regular session and convene in closed session.

VII. Adjourn

As the agenda was exhausted, Chairman Collens declared that the meeting was
ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Lewis M. Collens, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
October 9, 2013

ATTACHMENT #1

Culture of Safety Survey

CCHHS Board QPS Meeting
10/9/2013

Culture- A Definition

Healthcare organizations must develop a culture of safety such that an organization's care processes and workforce are focused on improving the reliability and safety of care for patients

-Institute of Medicine

A positive safety culture:

- Is associated with improved safety performance
- Has been shown to promote staff satisfaction and retention
- Can be improved through multi-component interventions

Joint Commission Standard

LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the hospital.

Rationale:

Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Leaders demonstrate their commitment to quality and set expectations for those who work in the hospital. Leaders evaluate the culture on a regular basis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the hospital, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance:

	DESCRIPTION	MOS	CR	DOC	SC	ESP
1	Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.				A	
2	Leaders prioritize and implement changes identified by the evaluation.				A	
3	Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.				A	

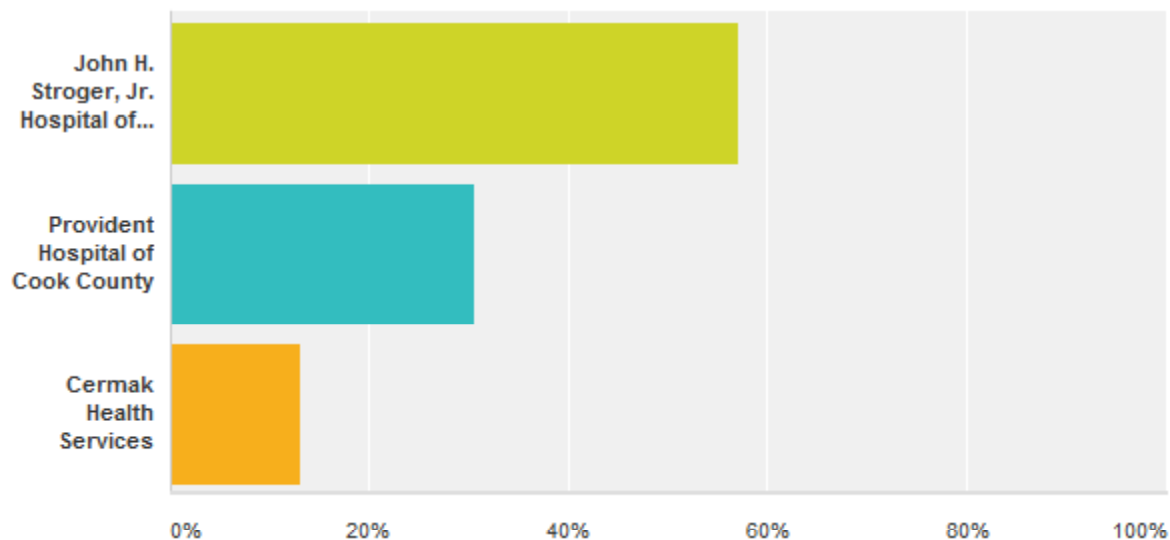
Our Survey

- Based on AHRQ (validated survey)
- Administered internally/ internet based
- Announced to leaders, via posters, and phone messaging
- Facilities: Provident, Stroger, Cermak (inpatient), ACHN (outpatient)
- Administered ~ 1month June-July 2013
- 1426 responses across system
- Inpatient data presented

Survey Responses-Inpatient

Please identify your primary unit within the Cook County Health and Hospitals System:

Answered: 728 Skipped: 24

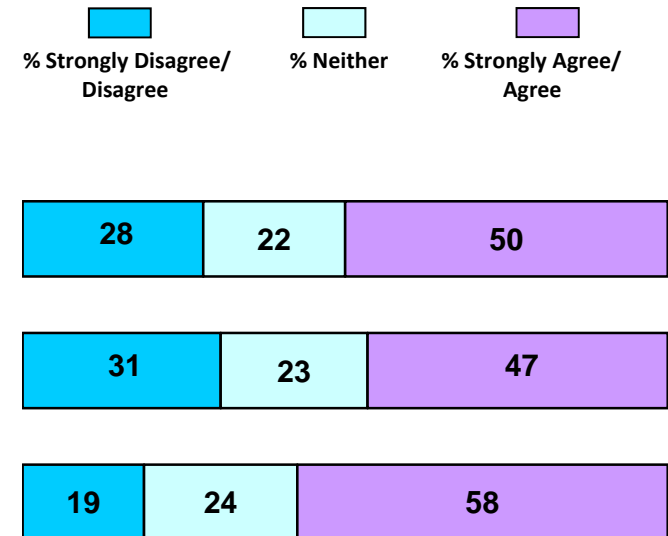


Answer Choices	Responses	
John H. Stroger, Jr. Hospital of Cook County	56.87%	414
Provident Hospital of Cook County	30.36%	221
Cermak Health Services	12.91%	94
Total Respondents: 728		

Non-punitive Response to Error

Survey Items




- ^R1. Staff feel like their mistakes are held against them.
- ^R2. When an event is reported, it feels like the person is being written up, not the problem.
- ^R3. Staff worry that mistakes they make are kept in their personnel file.



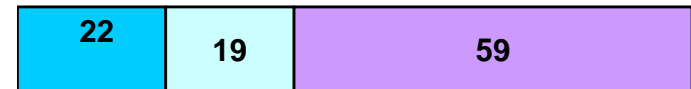
% positive: 26%

Supervisor/Manager Expectations & Actions Promoting Patient Safety

Survey Items

 % Strongly Disagree/
Disagree  % Neither  % Strongly Agree/
Agree

1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
2. My supervisor/manager seriously considers staff suggestions for improving patient safety.
- ^R3. Whenever pressure builds up, my supervisor/manager wants us to work faster, or take shortcuts.
- ^R4. My supervisor/manager overlooks patient safety problems that happen over and over.



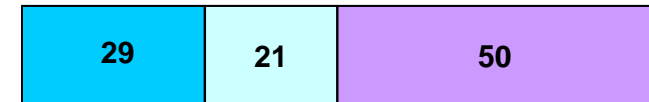
% positive: 60%

Feedback and Communication About Error

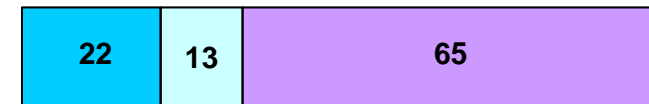
Survey Items



1. We are given feedback about changes put into place based on event reports.



2. We are informed about errors that happen in this unit.



3. In this unit, we discuss ways to prevent errors from happening again.

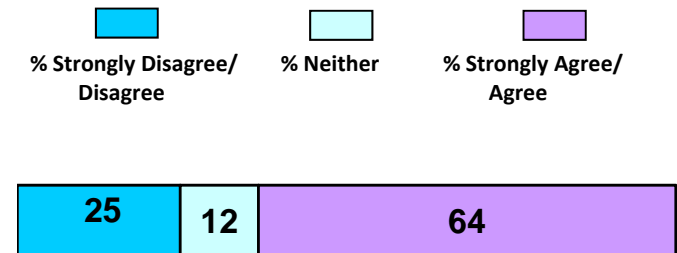


% positive: 60%

Teamwork Within Units

Survey Items

1. People support one another in this unit.



2. When a lot of work needs to be done quickly we work together as a team to get the work done.

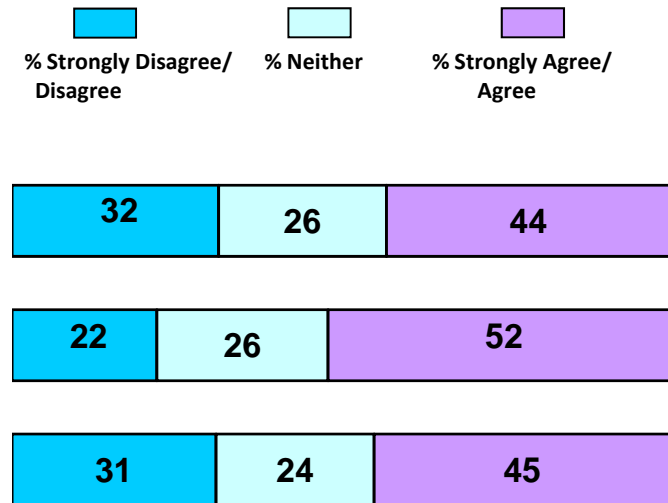


% positive: 66%

Teamwork Across Hospital Units

Survey Items

1. There is good cooperation among hospital units that need to work together.
2. Hospital units work well together to provide the best care for patients.
- ^R3. Hospital units do not coordinate well with each other.



% positive: 42%

Major Findings

Staff Perception of Safety

- Positive:
 - Managers set expectations for safety
 - Teamwork within units is good
 - There is feedback about safety events
- Negative:
 - Reluctance to report events due to fear of a punitive response
 - Handoffs and communication between hospital units could be improved

Building a Culture of Safety

Requirements

- Leadership
- Safety systems
- Occurrence reporting & organizational learning
- Teamwork and communication
- Attitudes
- Job demands and staffing

Leadership and Systems

- Current Systems:
 - Commitment to safety
 - Systems to identify and record adverse events
- Future Directions:
 - Explicit communications with staff emphasizing safety as a priority
 - Weekly safety update to leadership
 - Leadership 'walk-rounds'
 - Patient safety officer
 - Safety councils

Reporting and Organizational Learning

- Current Systems:
 - On-line secure reporting system with PSO
 - Departmental and hospital oversight coupled with process improvement and education (M&M)
 - Robust RCA program including front line personnel and emphasis on a non-punitive 'systems' approach
- Future Directions:
 - Formal recognition of staff who report safety concerns
 - Feedback to those who report safety concerns
 - Formal feedback from RCA/oversight process to disseminate interventions and 'just culture' concepts¹⁴

Communication & Teamwork

- Current Systems:
 - Interdisciplinary Rounds: medical-surgical units, ICUs
 - Communication Training: SBAR, time-outs
- Future Directions:
 - Formal interpersonal and teamwork training
 - Develop more robust handoff strategies

Questions

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
October 9, 2013

ATTACHMENT #2

John H. Stroger, Jr. Hospital of Cook County



Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Bieniarz, Andre, MD Appointment Effective:	OB/GYNE/Maternal Fetal Medicine October 9, 2013 thru October 8, 2015	Active Physician
Dominguez, Virginia, DDS Appointment Effective:	Surgery/Oral Health October 9, 2013 thru October 8, 2015	Active Dentist
Hinami, Keiki, MD Appointment Effective:	Medicine/Collab. Research Unit October 9, 2013 thru October 8, 2015	Active Physician
Kendall, Andrew, DO Appointment Effective:	Emergency Medicine October 9, 2013 thru October 8, 2015	Consulting Physician
Raza, Syed, MD Appointment Effective:	Correctional Health Services/Psychiatry October 9, 2013 thru October 8, 2015	Voluntary Physician
Stulberg, Debra, MD Appointment Effective:	Family Medicine/Family Planning October 9, 2013 thru October 8, 2015	Voluntary Physician
Will, Kenneth, MD Appointment Effective:	Emergency Medicine/Adult Emergency October 9, 2013 thru October 8, 2015	Consulting Physician
Yamani, Naser, MD Appointment Effective:	Medicine/ACHN October 9, 2013 thru October 8, 2015	Active Physician

Initial Non-Physician Appointment Applications

Baez, Joseph A., PA-C With Kysia, Rashid Fuad, MD Alternate Sherman, Scott C., MD Effective:	Emergency Medicine October 09, 2013 thru October 08, 2015	Physician Assistant
Lueders, Zachary H., PA-C With Sherman, Scott C., MD Alternate Moskoff, Jordan B., MD Effective:	Emergency Medicine October 09, 2013 thru October 08, 2015	Physician Assistant
Warden-Thomas, Karin A., CNP Smith, Patrika L., MD Effective:	Medicine / General Medicine October 09, 2013 thru October 08, 2015	Nurse Practitioner

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology

Konefal, Tadeusz, MD Reappointment Effective:	Clinical Adult Anesthesia November 15, 2013 thru November 14, 2015	Active Physician
Torres, Maria, MD Reappointment Effective:	Pain Management November 18, 2013 thru November 17, 2015	Active Physician

A handwritten signature in black ink, appearing to be a stylized 'S' or 'D' with a loop, is written over the bottom right portion of the page, partially overlapping the 'APPROVED' stamp.

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Correctional Health Services

De Funiak, Andrew, MD	Family Medicine	Active Physician
Reappointment Effective:	November 18, 2013 thru November 17, 2015	

Department of Emergency Medicine

Thompson, Trevonne, MD	Toxicology	Voluntary Physician
Reappointment Effective:	November 20, 2013 thru November 19, 2015	

Department of Medicine

Brannegan, Richard T., MD	Neurology	Active Physician
Reappointment Effective:	November 18, 2013 thru November 17, 2015	

Demetria, Melchor V., MD	Gastroenterology	Active Physician
Reappointment Effective:	November 15, 2013 thru November 14, 2015	

Huhn, Gregory D., MD	Infectious Disease	Active Physician
Reappointment Effective:	November 24, 2013 thru November 23, 2015	

Margeta, Natasa L., MD	Hospital Medicine	Active Physician
Reappointment Effective:	November 24, 2013 thru November 23, 2015	

Seo-Lee, Alisa T.L., MD	ACHN	Active Physician
Reappointment Effective:	October 21, 2013 thru October 20, 2015	

Vettiankal, Gijo G., MD	Gastroenterology	Active Physician
Reappointment Effective:	November 18, 2013 thru November 17, 2015	

Department of Obstetrics and Gynecology

Gamble, Tondalaya, MD	Obstetrics and Gynecology	Active Physician
Reappointment Effective:	October 21, 2013 thru October 20, 2015	

Rezai, Parto, MD	Reproductive Endocrinology	Voluntary Physician
Reappointment Effective:	October 18, 2013 thru October 17, 2015	

Department of Pathology

Niklinski, Waldemar, MD	Anatomic Pathology	Active Physician
Reappointment Effective:	November 20, 2013 thru November 19, 2015	

Department of Pediatrics

Echiveeri, Susan C., MD	Pediatrics Genetic Metabolism	Active Physician
Reappointment Effective:	November 13, 2013 thru November 12, 2015	

Enger, Minyuen Chang, MD	Neonatology	Active Physician
Reappointment Effective:	November 15, 2013 thru November 14, 2015	


Fujara, Marjorie R., MD	Child Protective Services	Active Physician
Reappointment Effective:	November 16, 2013 thru November 15, 2015	

Henry-Reid, Lisa M., MD	Adolescent Medicine	Active Physician
Reappointment Effective:	November 16, 2013 thru November 15, 2015	

Item IV(B) – October 9, 2013

CCHHS Quality and Patient Safety Committee Meeting

Page 2 of 4



CCHHS
APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON OCTOBER 9, 2013

Page 23 of 106

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications
Department of Pediatrics (continued)

Jacobson, Phillip A., MD Reappointment Effective:	Pediatrics/Critical Care Unit October 21, 2013 thru October 20, 2015	Active Physician
Patel, Mita, MD Reappointment Effective:	ACHN October 18, 2013 thru October 17, 2015	Active Physician
Romantseva, Lubov F., MD Reappointment Effective:	Peds Medicine October 09, 2013 thru October 08, 2015	Voluntary Physician
Soglin, David F., MD Reappointment Effective:	Pediatric Medicine November 24, 2013 thru November 23, 2015	Active Physician

Department of Psychiatry

Arenas, Virgilio, MD Reappointment Effective:	Psychiatry October 21, 2013 thru October 20, 2015	Consulting Physician
Khattak, Samina, MD Reappointment Effective:	Psychiatry November 15, 2013 thru November 14, 2015	Active Physician

Department of Radiology

Caluser, Calin, MD Reappointment Effective:	Special Procedure November 18, 2013 thru November 17, 2015	Active Physician
--	---	------------------

Renewal of Privileges for Non-Medical Staff

Kanumury, Ratna P., PA-C With Murray, Linda Rae, MD Alternate Thomas, Bonnie W., MD With Fegan, Claudia M., MD Alternate Murray, Linda Rae, MD Effective:	Medicine / Occ. Medicine/Pulmonary Medicine / General Medicine October 21, 2013 thru October 20, 2015	Physician Assistant
Quezada-Gomez, Carlos, PsyD Effective:	Correctional Health Services/Psychology October 21, 2013 thru October 20, 2015	Clinical Psychologist
Schoen, Alison M., PA-C With De Funiak, Andrew Q., MD Alternate Andrew Ting, MD Effective:	Correctional Health Services December 16, 2013 thru December 15, 2015	Physician Assistant
Thomas, Barbara, PhD Effective:	Psychiatry/Adult Ambulatory November 15, 2013 thru November 14, 2015	Clinical Psychologist

Non-Medical Staff Change in Clinical Privileges

West Paul E. III, PA-C With Hollowell, Courtney M., MD Alternate Wille, Mark A., MD Effective:	Surgery / Urology October 09, 2013 thru May 14, 2014	Physician Assistant
---	---	---------------------

Provident Hospital of Cook County



Medical Staff Reappointments and Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPLICATION

Abadin, Shabirhusain, MD Appointment Effective:	General Surgery October 9, 2013 thru September 22, 2015	Affiliate Physician
--	--	---------------------

REAPPOINTMENT APPLICATIONS

Department of Internal Medicine

Fogelfeld, Leon, MD Reappointment Effective:	Internal Medicine/Endocrinology November 24, 2013 thru November 23, 2015	Affiliate Physician
Mallick, Naveed K., MD Reappointment Effective:	Internal Medicine October 9, 2013 thru October 8, 2015	Active Physician
Rubinstein, Paul G., MD Reappointment Effective:	Internal Medicine/Hema-Oncology October 18, 2013 thru July 27, 2015	Affiliate Physician

Department of Radiology

Javier, Calvin, MD Reappointment Effective:	Radiology October 16, 2013 thru October 15, 2015	Active Physician
Marmo, Frank, MD Reappointment Effective:	Radiology October 16, 2013 thru October 15, 2015	Active Physician

A handwritten signature, likely of a committee member, is written over the approval text.

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
October 9, 2013

ATTACHMENT #3

Cook County Department of Public Health

Report to CCHHS Board Quality & Patient Safety Committee

September 23, 2013

- Update on PHAB
- Update on 2015 Strategic Plan
- Update on Quality Activities
- Report on STI's
- Report on Tuberculosis

Linda Rae Murray M.D. MPH FACP
Chief Medical Officer, CCDPH





Strategic Plan: VISION 2015

Mission

To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County.

Vision 2015

In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally—and by patients and employees—as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.

Core Goals

I. Access to Healthcare Services

II. Quality, Service Excellence & Cultural Competence

III. Service Line Strength

IV. Staff Development

V. Leadership & Stewardship

Strategic Initiatives

- Eliminate System access barriers at all delivery sites.
- Designate and develop 3-5 regional delivery sites for provision of comprehensive outpatient services.
- Rebuild Fantus Clinic and expand parking capacity; evaluate optimal long-term development of Provident, Oak Forest, and ACHN sites.

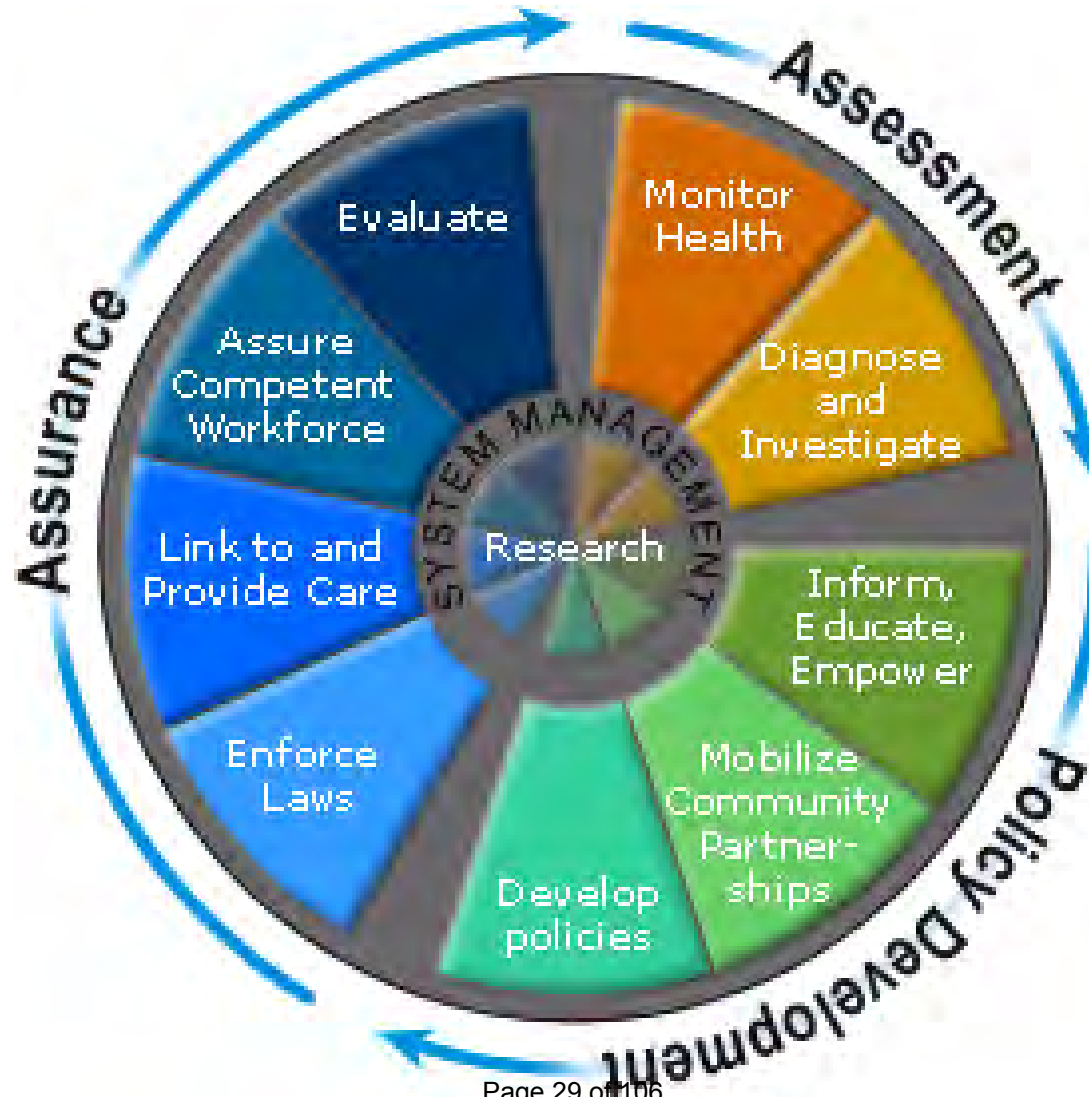
- Develop an integrated, System-wide approach and supportive infrastructure for patient-centered care coordination.
- Implement a System-wide program of continuous process improvement: patient care quality, safety, and outcomes.
- Develop a comprehensive program to instill cultural competency.

- Develop/strengthen clinical service lines in needs-based areas such as cancer, cardiac, diabetes, emergency/trauma, burn, HIV/AIDS, rehabilitation and surgery; evaluate optimal development of OB, pediatrics, neonatal care.
- Pursue mutually beneficial partnerships with community providers.
- Assure the provision of the Ten Essentials of Public Health.

- Implement a full range of initiatives to improve caregiver/employee satisfaction.
- Focus on effective recruiting and retention processes.
- Develop a robust program for in-service education and professional skill building.

- Foster leadership development and succession planning.
- Develop long-term financial plans and sustaining funding.
- Hold Board and management leadership accountable to agreed-upon performance targets.

Ten Essential Public Health Services



Cook County Department of Public Health 2015 Strategic Plan

Mission

To optimize health and achieve health equity for all people and communities of Cook County through our leadership and collaborations, focusing on health promotion and prevention, while advocating for and assuring the natural environmental and social conditions necessary to advance physical, mental and social well-being.

Vision

The Cook County Department of Public Health envisions a healthy Cook County where all people and communities thrive in safe, health-promoting conditions.

Values

**QUALITY & STEWARDSHIP * DIVERSITY * INTEGRITY * RESPECT *
TEAMWORK * HEALTH EQUITY * PROACTIVE INTERVENTION**

Cook County Department of Public Health 2015 Strategic Plan

Mission

To optimize health and achieve health equity for all people and communities of Cook County through our leadership and collaborations, focusing on health promotion and prevention, while advocating for and assuring the natural environmental and social conditions necessary to advance physical, mental and social well-being.

Vision

The Cook County Department of Public Health envisions a healthy Cook County where all people and communities thrive in safe, health-promoting conditions.

Goals

1. Leading Public Health in Cook County

2. Improving Health

3. Achieving Accreditation and Assuring Quality

4. Strengthening Organizational Capacity

Strategic Initiatives

- Examine feasibility of one public health authority in Cook County.
- Increase collaboration and coordination across all six local health departments in Cook County.
- Establish platform to exchange data directly with the Illinois Health Information Exchange.
- Design and implement population health multi-disciplinary teams.
- Direct public health initiatives for the Cook County Health & Hospital System, and integrate CCDPH clinical services.

- Implement Strategic Health Plan, addressing 8 health priorities using evidence-based practice and outcomes measurement.
- Engage multiple sectors and communities in Cook County to address health priorities.

- Apply for national accreditation and promote application by local health departments in Illinois.
- Develop a Quality Assurance Plan and incorporate findings for program changes and staff development.

- Create an organizational culture that encourages staff to increase public health proficiency.
- Increase modes and quality of internal and external communications.
- Implement information technology initiatives to enhance productivity.
- Identify new funding opportunities in alignment with mission.

Cook County Department of Public Health 2015 Strategic Plan :

Report on August 2012- August 2013 Activities

Mission

To optimize health and achieve health equity for all people and communities of Cook County through our leadership and collaborations, focusing on health promotion and prevention, while advocating for and assuring the natural environmental and social conditions necessary to advance physical, mental and social well-being.

Vision

The Cook County Department of Public Health envisions a healthy Cook County where all people and communities thrive in safe, health-promoting conditions.

Goals

1. Leading Public Health in Cook County

2. Improving Health

3. Achieving Accreditation and Assuring Quality

4. Strengthening Organizational Capacity

Strategic Initiatives

- CCDPH has not been able to implement the specifics of the 2015 plan. We continue to play a leading role in NIPC, NACCHO, IPHA, APHA
- We successfully transferred DENTAL services to ACHN (still providing back office support)
- “Virtual” TB integration at Oak Forest Campus

- We remain with our original 4 cross disciplinary teams (Access to Care, CVD, Sexual Health, Violence Prevention) and are unable to add teams as planned. All teams are making progress on their work plans.
- *CCDPH established its Community Health Advisory Committee (CHAC) which now has regular meetings.*

- We remain a state certified health department meeting all standards and state inspections and audits. (e.g. CLIA)
- We are on target for national PHAB accreditation
- The departmental QA committee has been institutionalized with clear work plans for next year.

- Almost 20% of the department had training in our chosen quality process many earned formal CEs
- About 15% of the department earned CE in a health equity course.



**DISCRETIONARY
PROGRAMS**

***REQUIRED FOR COMMUNITY
HEALTH IMPROVEMENT PLAN
Will be discussed another time.***

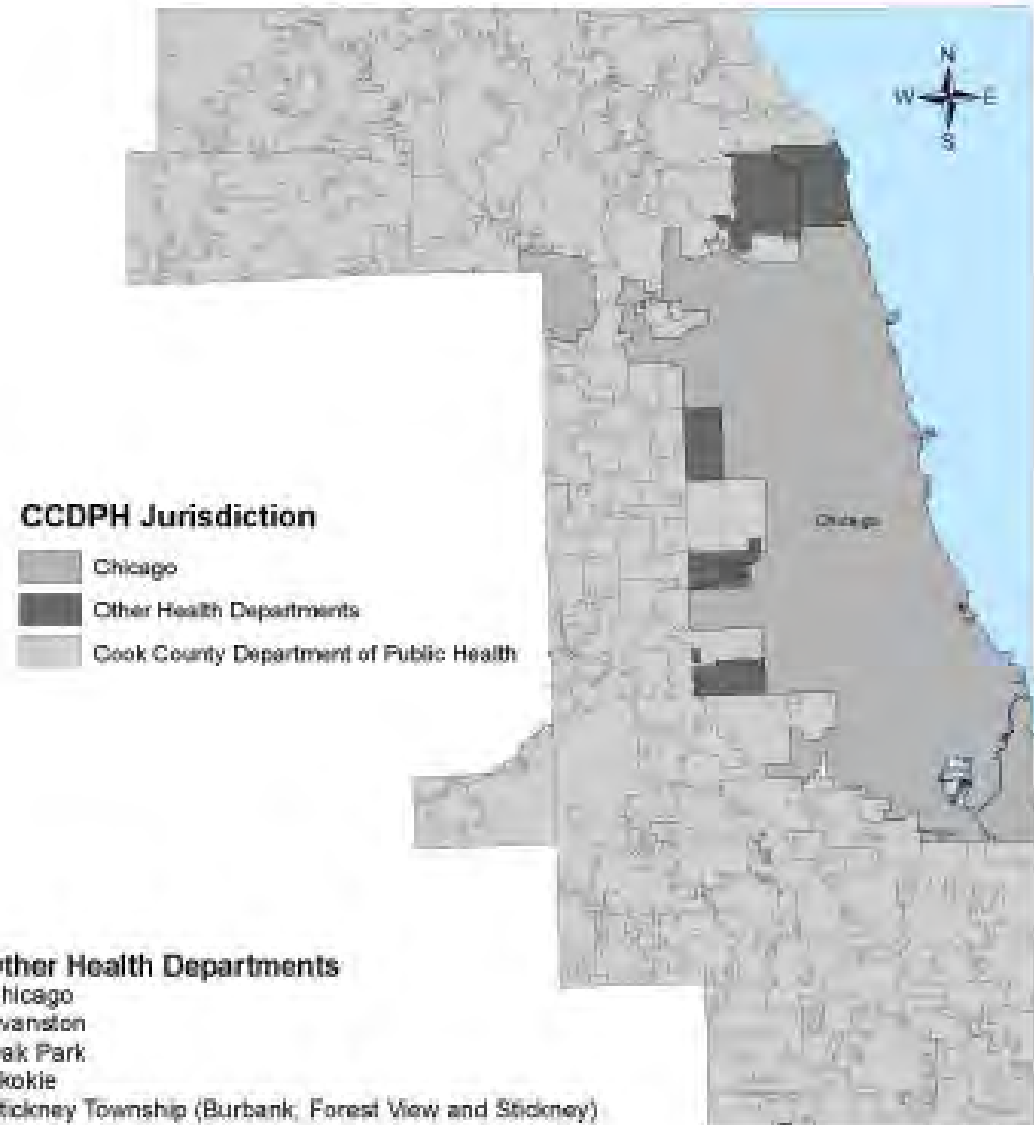
***Mandated
Public Health
Services for
Certified Health
Departments in
Illinois 2010***

REQUIRED FOR LOCAL HEALTH PROTECTION GRANT
Infectious Disease, Food Protection, Potable Water Supply, Private
Sewage disposal

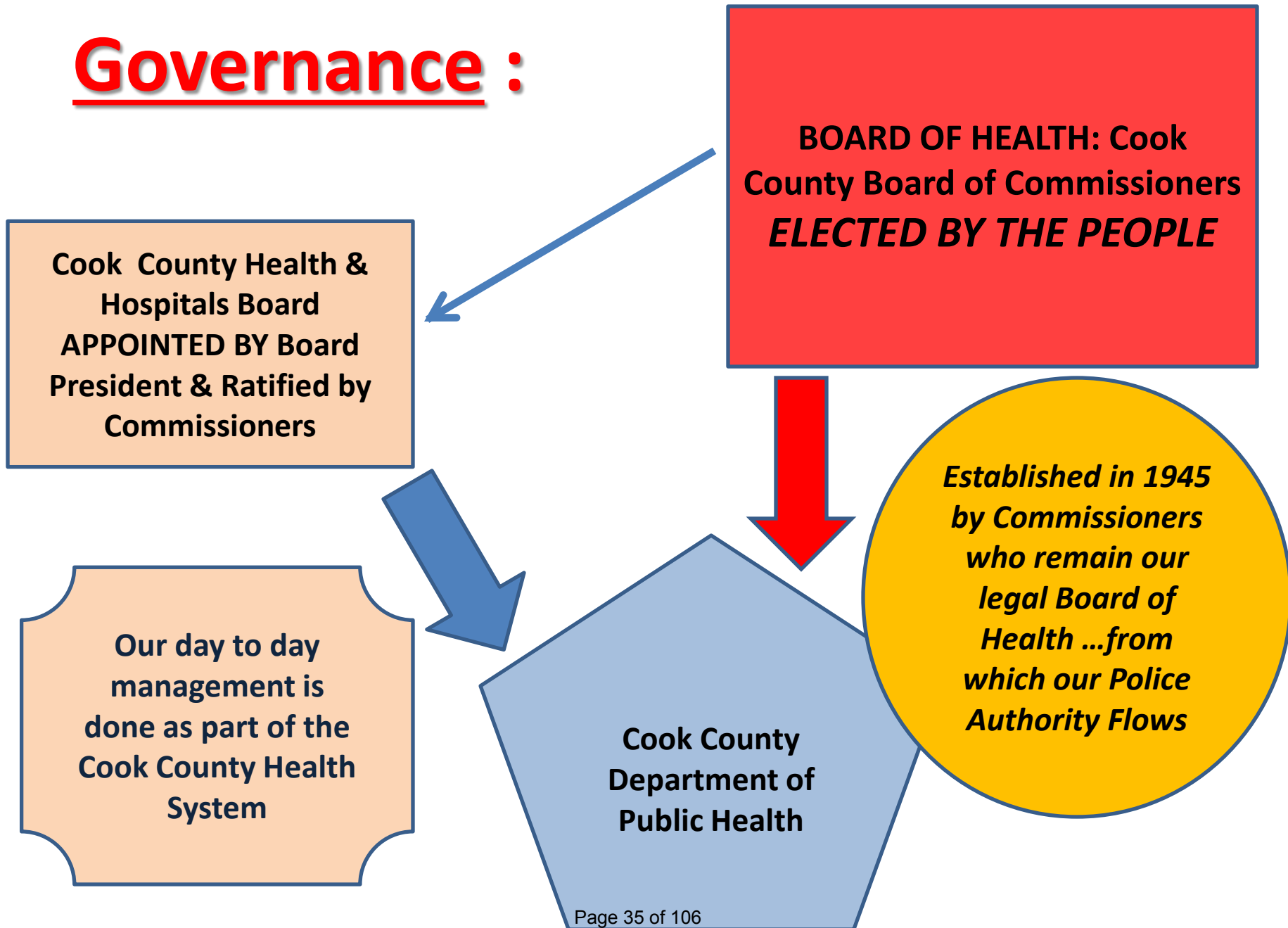
**REQUIRED FOR LOCAL HEALTH DEPARTMENT
CERTIFICATION:**
Emergency Preparedness & Response, Disease Monitoring &
Control Services, Community Health Assessment & Planning,
Health Communications, Health Data, Quality Improvement and
Accreditation, Policy Development, Food & Water Safety,
Organizational Management, High Risk Infant Follow-up

BASIC JURISDICTION

- All of Cook County EXCEPT where there is a state certified health department.
- Most activities takes place in this geography.



Governance :



Cook County Department of Public Health



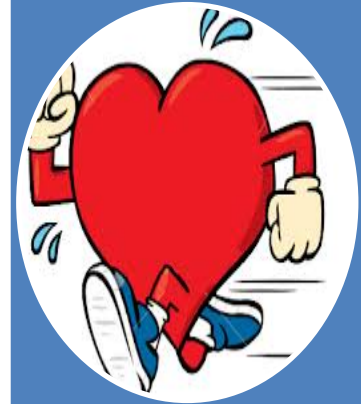
Prevent
Communicable
Diseases &
control spread



Environmental
Protection



Clinical Programs
(Categorical:STIs,
Family Planning, TB)
Population Based:
High Risk Infants,
Immunization, WIC)



Prevention
Services Unit

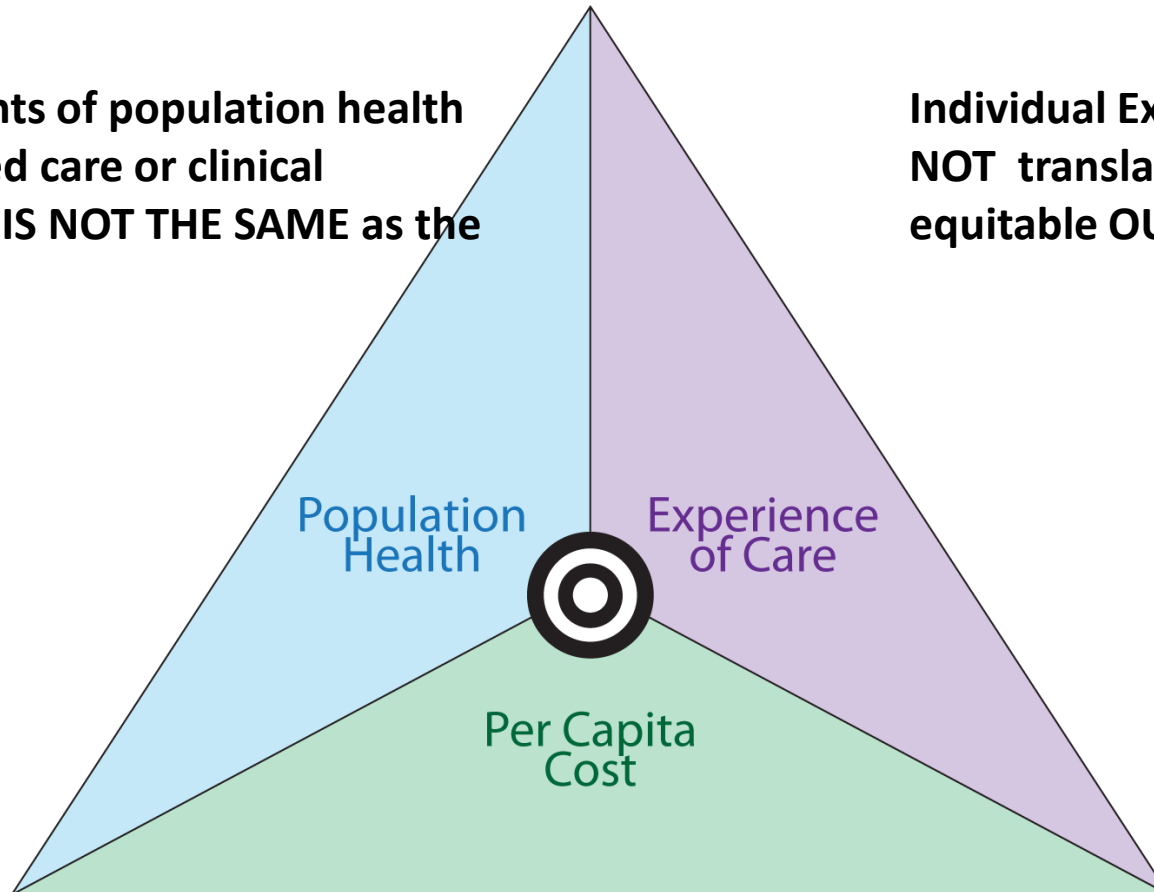
***EPIDEMIOLOGY * EMERGENCY PLANNING & RESPONSE *
POLICY * COMMUNICATIONS***

SUPPORT SERVICES: Management * *Finances* * *Human Resources* * IT

IHI – Triple Aim of Quality

**Determinants of population health
.....Managed care or clinical
population IS NOT THE SAME as the
Public.**

**Individual Experience MAY
NOT translate into
equitable OUTCOMES**



**Decrease in per capita health system costs MAY REQUIRE increase
in per capita societal investment.**

PERFORMANCE MANAGEMENT

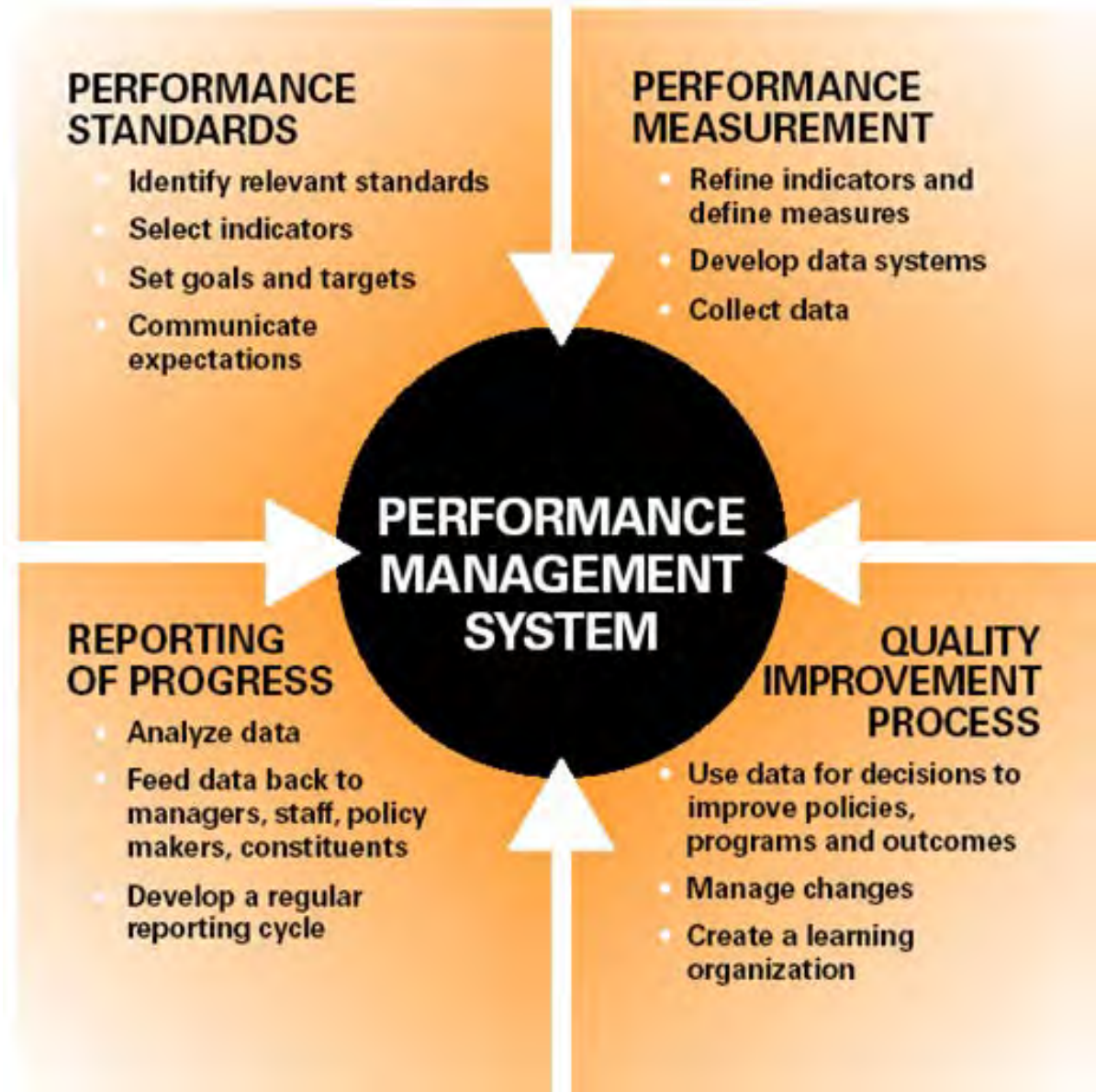
An integrated system.

For more details review :

TURNING POINT: From Silos to Systems: Using Performance Management to Improve the Public's Health.

PERFORMANCE MANAGEMENT: is the practice of actively using performance data to improve the public's health.

A PERFORMANCE MANAGEMENT SYSTEM: is the continuous use of all practices so that they are integrated into an agency's core operations. PM can be carried out at multiple levels.



EMBRACING QUALITY IN LOCAL PUBLIC HEALTH



.....
Debra Scamarcia Tews
Marti Kay Sherry
James A. Butler
Angela Martin

Where

Did

We

Begin?

Complete System

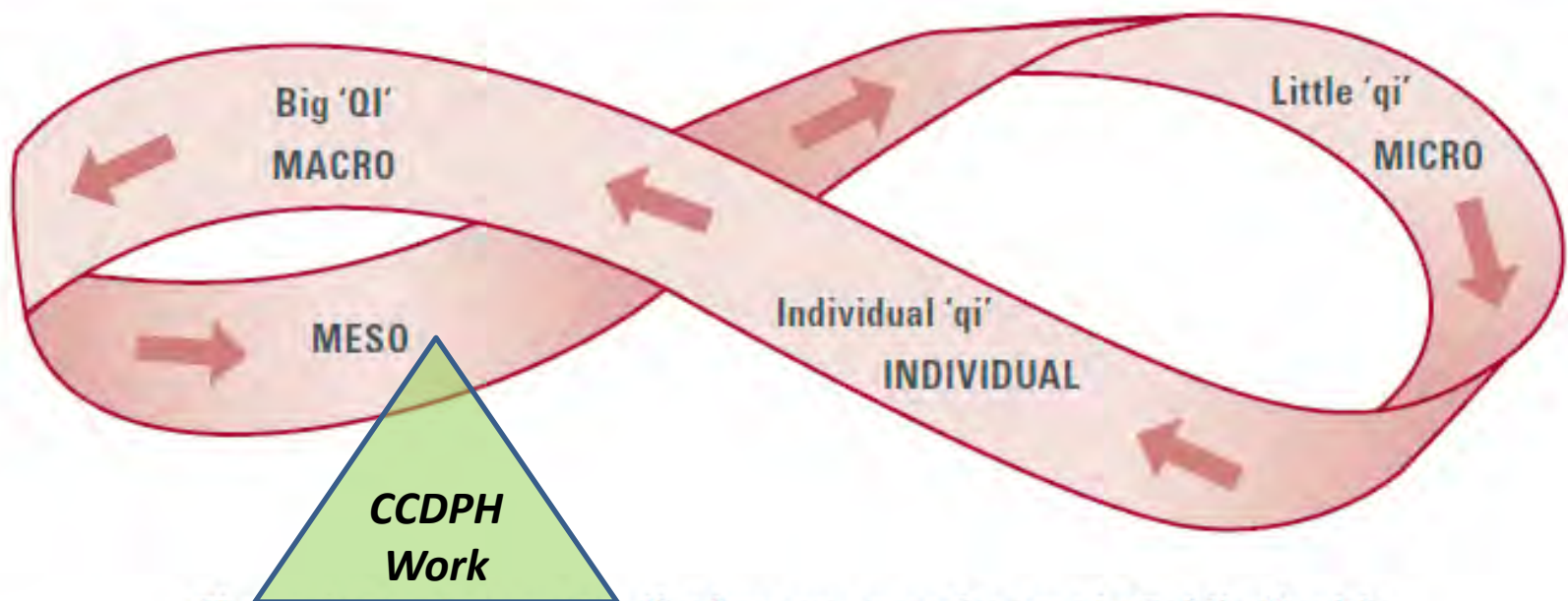


Figure 1: Continuous Quality Improvement System in Public Health

Summary of QA Committee FY 2012 – August 2013

- **Increased knowledge about quality process training over 10% of the department**
- **Successfully had regular meetings of five teams**
- **Recognized critical role of “Clueless” team member.**
- **Many measures “refined” to reflect what we are really trying to improve.**

Work plans for FY 2014

- **Line staff will be increased on all teams**
- **Department Committee will be refreshed with more line staff**
- **Team leaders will expand to include program participants**
- **Education about quality tools will be driven down to team level.**

Summary of Team plans

- **Lead: our oldest team. Expanding measures outside of department**
- **Environmental Health: Were not monitoring these measures before. Amendments Cook County Public Health & Private Nuisance Ordinance passed in July must be addressed.**
- **CD: stubborn measures. A few interim measures will be added.**

Summary of Team Plans

- Tuberculosis: adding measures from national goals. Have “refined” some measures (e.g. IDPH)
- HIGH RISK INFANTS: *Has metastasized (a good thing!)*
 - Most nurses trained. QA teams being formed in each district and choosing indicators.

Quality Improvement Indicators FY 2013- 14 *Department Level*

Performance Indicator	Dec 1, 2012 – June 2013	FY 2013
Achieve National Public Health Accreditation through the PHAB (Public Health Accreditation Board)	ON TARGET Submission completed June 2013	Accreditation by December 31, 2013

ON TARGET



Application Prerequisites

- Submit 3 prerequisites *(Approved by CCHHS Board & Cook County Board of Commissioners in June 2011)*
 - *Community Health Assessment (WePlan 2015)*
 - *Community Health Improvement (WePlan 2015)*
 - *CCDPH Strategic Plan 2015*
- PHAB training of Accreditation Coordinator



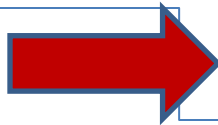


7 Steps: PHAB Public Health Accreditation Board

7. Reaccreditation

6. Reports

5. Accreditation Decision



4. Site Visit

3. Documentation Selection & Submission

2. Application

1. Pre-application

**JUNE 15 ,
2013**



Public Health Accreditation Domains



Quality Improvement Indicators FY 2013 – 14 *Lead Poisoning Prevention*

Performance Indicator	Dec 1, 2012 –June 2013	FY 2013 TARGET
Percent of cases with elevated blood lead (EBL) <i>visited by a PUBLIC HEALTH NURSE:</i> * EBL 20-39 : home visit within 10 business days * EBL 40 – 69: home visit within 5 business days * EBL 70 and greater: home visit within 2 business day	100% nc 100%	95% 95% 95%
Percent of children with EBLs of 20 or greater that receive <i>a joint home visit</i> from a public health nurse and an environmental inspector	100%	95%
Proportion of referrals from IDPH Stellar system <i>referred to CCDPH units within 2 days of receipt</i>	100%	95%
Proportion of <i>mitigation orders</i> that are developed within 10 business days of the environmental inspection	93%	95%

Quality Improvement Indicators FY 2013 – 14 *Lead Poisoning Prevention*

Performance Indicator	Dec 1, 2012 – May 2013	FY 2013 TARGET
Proportion of <i>child care providers</i> in high risk zip codes that are <i>educated</i> on incorporating lead screening & testing policies in their parent handbooks.	41%	90%
Number of <i>healthcare providers</i> serving children in high risk zip codes that <i>receive education</i> on lead screening policies and Medicaid pay-for-performance incentives for testing.	19%	50%
Number of private residences that receive mitigation/abatement services to correct lead based paint hazards.*	20%	80%
<i>* Dependent on grant funding levels</i>		

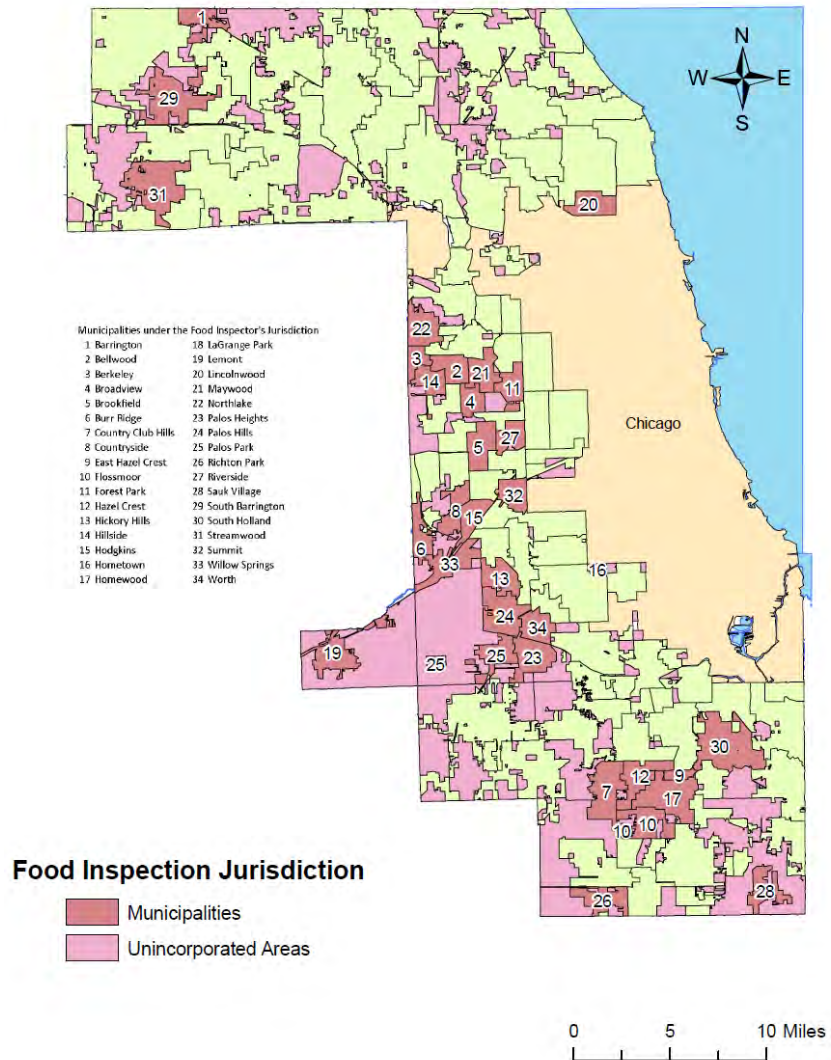
CCDPH Food Inspection Jurisdiction

FOOD INSPECTION

* CCDPH is responsible for food inspections in UNINCORPORATED Cook County

* CCDPH provides on a **CONTRACTED** basis food inspections in certain suburban communities.

*CCDPH is responsible for **FOOD BORNE OUTBREAKS OF ILLNESS** everywhere in suburban Cook County where there is **NOT** a state certified local health department.



Quality Improvement Indicators FY 2013-14

Environmental Health - Food Program*

Performance Indicators	Dec 1, 2012 – June 2013	FY 2013
Percent of food establishments with isolated illness complaints within non-contract communities that are referred to the appropriate licensing authority within 2 business days.	83%	100%
Percentage of food establishments with non-illness related complaints (e.g. rodents, odors etc) in contract or unincorporated communities investigated within 5 business days.	95%	90%
Percentage of food establishments with non-illness related within non-contract communities that are referred to the appropriate licensing authority within 2 business days.	97%	100%

Quality Improvement Indicators FY 2013 -14

Environmental Health - Nuisance Program*

Performance Indicators	Dec 1, 2012 – June 2013	FY 2013
Percent of nuisance complaints related to failing private sewage disposal systems in suburban Cook County that are investigated within 5 business days of receipt of complaint.	90%	100%
Percentage of nuisance complaints NOT RELATED to failing private sewage disposal systems in unincorporated suburban Cook County that are investigated within 10 business days of receipt of the complaint.	97%	90%
Percentage of nuisance complaints determined to be the responsibility of other jurisdictions that are referred to the appropriate agency within 3 business days of receipt of the complaint.	98%	100%

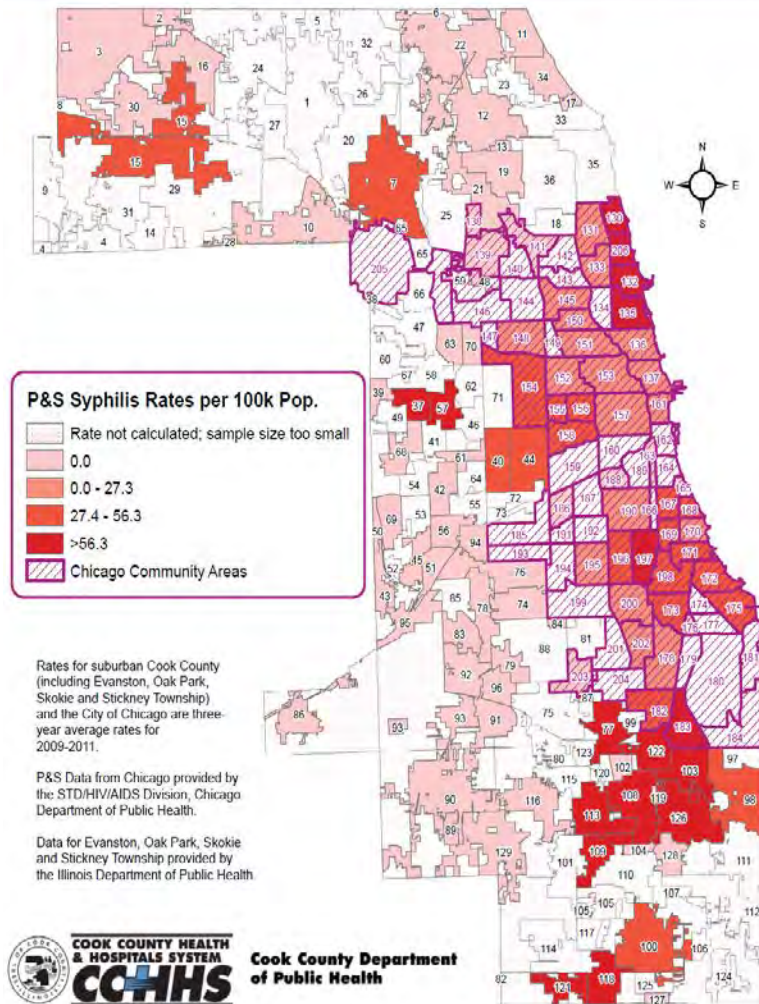
**** AMMENDMENTS OF PUBLIC HEALTH & NUISANCE ORDINANCE PASSED IN JULY 2013 WE ARE PREPARING OUR PROCESSES TO BE IN COMPLIANCE WITH DIRECTIVE FROM OUR BOARD OF HEALTH.***

Quality Improvement Indicators FY 2013- 14 *Communicable Disease*

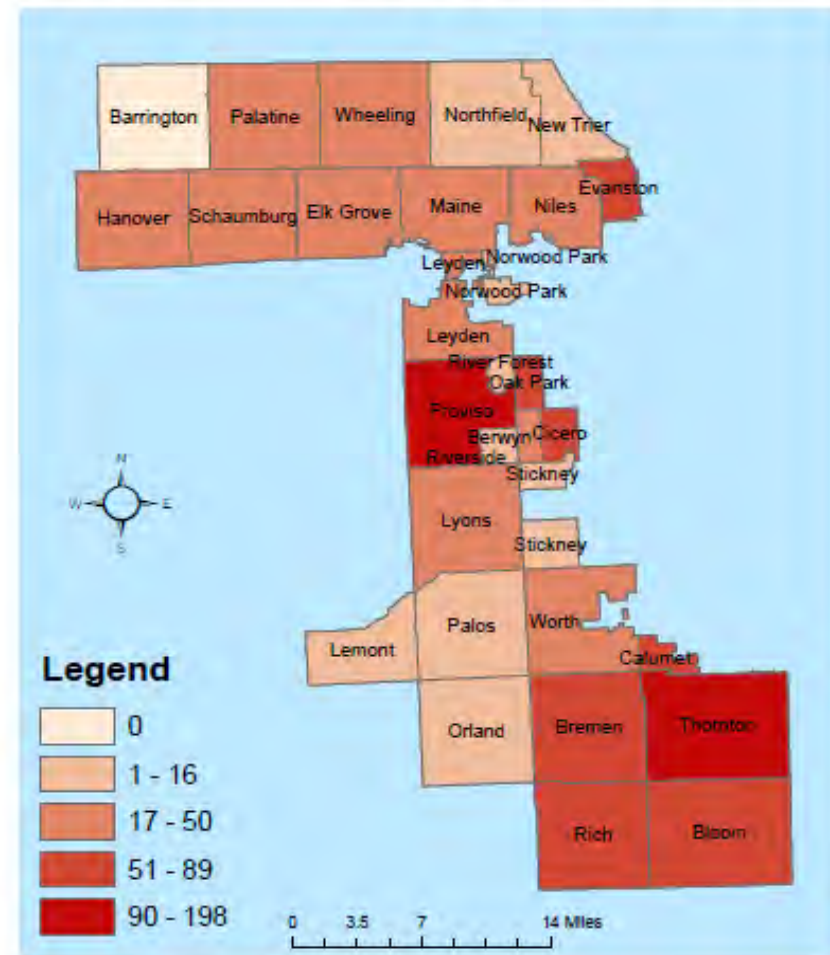
PERFORMANCE INDICATOR	Dec 1, 2012 – June 2013	FY2013
Percentage of primary & secondary syphilis cases (P&S) referred to field investigation or assigned final disposition within 3 business days	100%	95%
Percentage of P&S cases receiving a phone call within 3 business days of field assignment.	100%	95%
Average Contact per Index case of P&S syphilis	0.6	1.0
Percentage of P&S cases closed within 30 days of field assignment	87%	95%
Percentage of locatable partners to a confirmed case of P&S syphilis referred for testing and/or treatment.	73%	75%

BIG DOT ISSUE: Suburban Cook is now the epicenter for HIV in state.

Figure 14. Average P&S Syphilis Rates (per 100,000 population by Municipality (Suburban Cook County) and Community Area (Chicago), 2009-2011



Region 8 HIV Incidence by Township, 2008-2012, Illinois

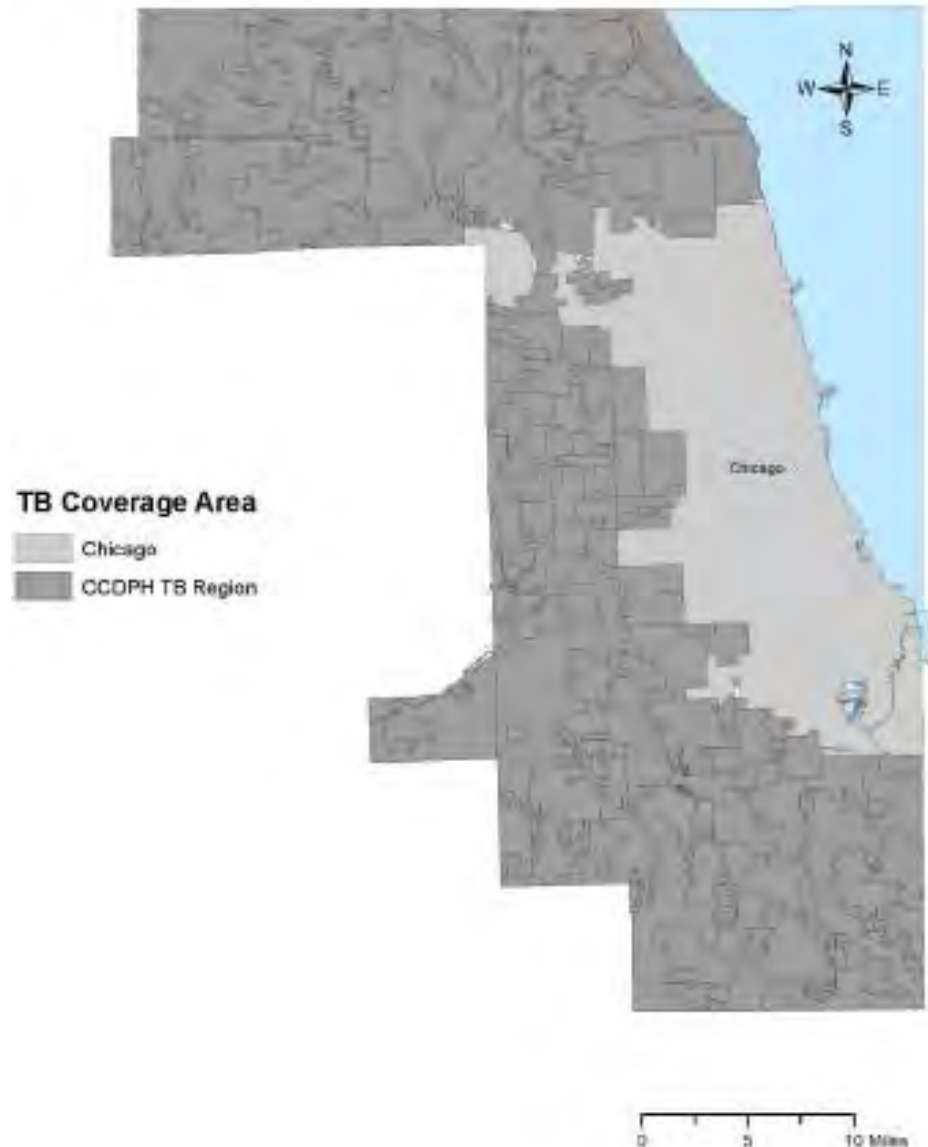


Quality Improvement Indicators FY 2013 – 14 *High Risk Infants*

Performance Indicators	Dec 1, 2012 – June 2013	FY 2013
Percent of high risk infants referrals received through the APORS (Adverse Pregnancy Outcome Reporting System) that are contacted for follow up by the Public Health Nurse within 14 calendar days of referral.	33%	100%
CCDPH will identify top ten referral diagnoses from APORS for suburban Cook County	In process	Top ten ICD/9ICD/10 DX identified
CCDPH will identify suburban Cook County zip codes with highest rates of top ten referral diagnoses for APORS	Complete	List of Cook County zip codes by ICD/9ICD/10 codes

CCDPH JURISDICTION FOR TUBERCULOSIS

- CCDPH has authority in ALL of suburban Cook County for TB
- The CCHHS now is responsible to make sure that clinical care is provided to people with TB in the city & suburbs. (Some patients are cared for by private physicians)
- CCDPH strategic plan calls for close coordination and eventual merger of TB clinical activities with the Division of Pulmonary Medicine at Stroger Hospital.
THIS IS ONGOING AND ON TARGET.
- CCDPH will maintain the population based (public health) services as required of a certified health department.

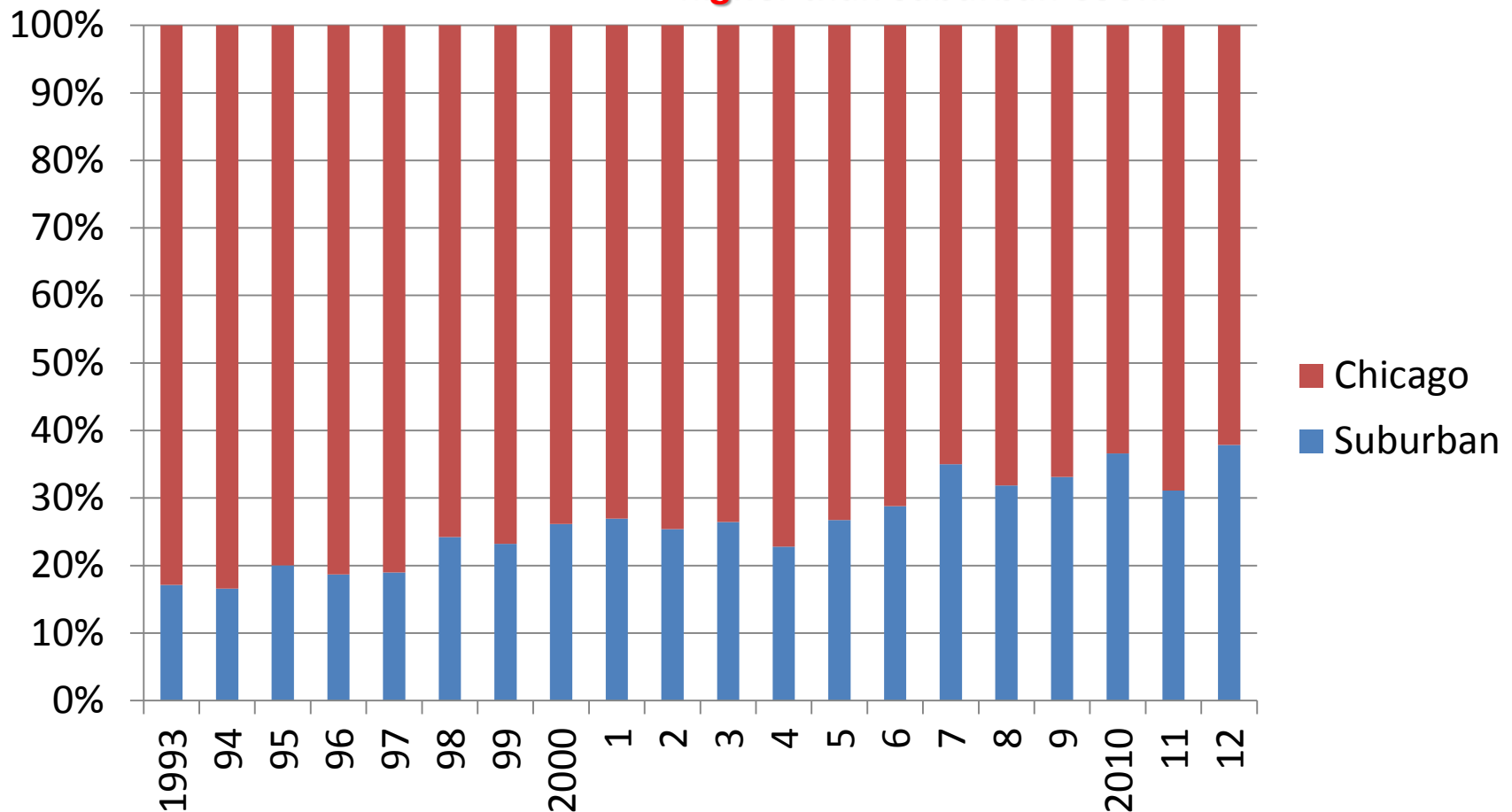


Quality Improvement Indicators FY 2013 – 14 **TUBERCULOSIS**

PERFORMANCE INDICATOR	Dec 1, 2012 – May 2013	FY 2013 TARGET
<u>COMPLETION OF RX:</u> For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated increase the proportion of patients who complete treatment within twelve months.	95%	93% (National 2015 target)
<u>INCREASE HIV TESTING</u> among patients with tuberculosis.	94%	90% (National 2015 target = 88.7%)
<u>CONVERSION OF SPUTUM CULTURE:</u> Increase the percentage of TB patients which positive sputum culture results who have documented conversion to sputum culture negative within 60 days of treatment initiation.	91%	78% (National 2015 target = 60%)

Tuberculosis in Chicago & Suburban Cook County

In 1993 the city had a rate **FOUR** times that of the suburbs. Today the rate is only **1.5** times higher than suburban Cook.



2010-2012

Overweight and Obesity Prevalence Among School-Aged Children in Suburban Cook County, Illinois

Introduction

Overweight and obesity among children is a major public health concern in suburban Cook County (SCC), where 40% of 9th graders are already overweight or obese compared to 32% of 9th graders in the U.S.¹

Preventing childhood obesity is important to our children's health and well-being. Children and young people who are obese are likely to be obese as adults² and are at increased risk of developing serious health problems including heart disease, type 2 diabetes, sleep apnea, depression and liver disease³. Obesity in children can have negative social and emotional consequences; for example, teasing and bullying⁴. Additionally, annual medical costs including prescription drug, emergency room, and outpatient costs for obese children in the U.S. are estimated to be \$14.1 billion per year⁵.

To determine the extent and distribution of overweight and obesity among school-aged children in SCC, the Cook County Department of Public Health in collaboration with the Consortium to Lower Obesity in Chicago Children at Ann and Robert H. Lurie Children's Hospital of Chicago conducted an assessment. This brief report shares key findings and recommendations for future efforts.

What was done

Body Mass Index (BMI)ⁱ, calculated using height and weight data recorded from student Certificate of Child Health Examination (CCHE) formsⁱⁱ, was collected from 37,702 students in 129 SCC public schools during school years 2010-11 and 2011-12. Data were available for students in kindergarten, 6th and 9th grades.

Children with age- and sex-adjusted BMI percentile scores of 85 to 94ⁱⁱⁱ are categorized as overweight, and those with scores above 94 are classified as obese. The sampling method used allowed for generalization of overweight and obesity estimates for public school students in SCC by age, grade and region in which they attend school.

Summary of Key Findings

1

Overall, the overweight and obesity rates in SCC are higher than national averages.

2

There are significant differences in obesity rates between regions.

3

Obesity rates in the west, south and southwest regions are higher than national rates.



Acknowledgements

Made possible by cooperative agreements from the Centers for Disease Control and Prevention (Grant Numbers: 1U58DP002623-01 and 3U58DP002623-01S1) to the Public Health Institute of Metropolitan Chicago (PHIMC) and the Cook County Department of Public Health (CCDPH).

2010-2012 Overweight and Obesity Prevalence Among School-Aged Children in Suburban Cook County, Illinois

1

Key Finding

Overall, overweight and obesity among SCC students are higher than national averages for children in similar age groups. These differences are statistically^{iv} significant for kindergarten and 9th grade.

Table 1 | Overweight and Obesity Rates, School Aged Children, Comparison of Suburban Cook County, Illinois and U.S.

	Kindergarten (4.5–6.5 years old)		6th Grade (10.5–12.5 years old)		9th Grade (13.5–15.5 years old)	
	% Overweight	% Obese	% Overweight	% Obese	% Overweight	% Obese
SCC	14.9	17.9	18.4	23.8	18.9	20.8
U.S.	11.4	12.7	18.6	20.4	15.4	16.7

U.S. Data Source: National Health and Nutrition Examination Survey (NHANES) data (2005–2010)

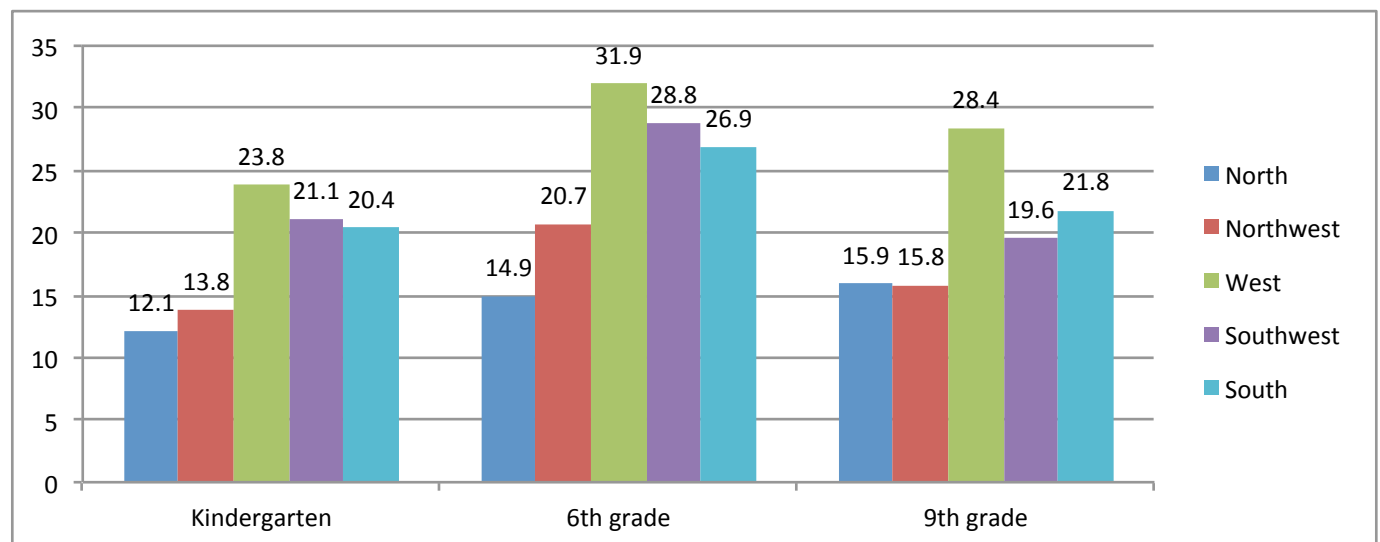
2

Key Finding

By SCC region, there are statistically significant differences in child obesity rates.

- Obesity rates in the west region of SCC are the highest for all grades.
- Obesity rates in the west, south and southwest regions of SCC are significantly higher than that of the north and northwest regions of SCC.
 - Obesity rates are generally twice as high in the west region of SCC as compared to the rates in the north.
 - Compared to the north region of SCC, obesity rates in the south and southwest regions are nearly 75% higher for kindergartners; over 80% higher for 6th grade students; and over 25% higher for 9th grade students.

Chart 1 | Obesity Rates by Region of Suburban Cook County, Illinois



2010-2012 Overweight and Obesity Prevalence Among School-Aged Children in Suburban Cook County, Illinois

3

Key Finding

Obesity rates in the west, south and southwest regions of SCC are higher than national rates for children in similar age groups.

- In the west region of SCC, the obesity rate for kindergartners is nearly twice the national rate; and is 64% and 58% higher, respectively, for 6th and 9th grade students than the national rate.
- Compared to national rates, obesity rates in the south and southwest regions of SCC are nearly 60% higher for kindergartners; over 85% higher for 6th grade students and nearly 25% higher for 9th grade students.



Recommendations

Childhood obesity affects thousands of children in SCC. Prevention is more cost effective than treatment of obesity. An integral part of the solution to addressing obesity is one that includes implementing policies **and** evidence-based programs that create supportive environments that promote healthy eating and active living.

Additionally, continued monitoring of child overweight and obesity prevalence in SCC is needed. These data, which are the first obesity prevalence rates available specifically for SCC, allow for understanding the extent and distribution of overweight and obesity among school-aged children in SCC. A system for continued surveillance is necessary to inform resource allocation decisions and to monitor progress in reducing overweight and obesity among SCC students.

Definitions

- Body Mass Index (BMI) is the relationship of height to weight.
- In Illinois, completed Certificate of Child Health Examination forms (CCHE) forms are required for all public school students by October 15th of their kindergarten, 6th and 9th school years. The CCHE is completed by parents and an authorized health professional. Parents complete a section on family background and chronic conditions. Health care providers provide clinically-measured and diagnosis data including weight and height. Demographics such as age, gender (and as of January 2013, race/ethnicity) are also included.
- Sex- and age-adjusted BMI percentile scores are used to determine weight status because children's growth fluctuates as they age and growth patterns differ by sex and age. Age- and sex-adjusted BMI percentile scores indicate how a child compares to others of the same age and sex. For example, a child with a BMI percentile score of 95 has a BMI greater than 95 of children his same age and sex. Weight status categories are assigned based on percentile scores. BMI percentile scores between 85 and 94 are categorized as overweight. BMI percentile scores equal to or greater than 95 are categorized as obese.
- When differences are described in this report as "statistically significant" or "significantly higher", it means that the likelihood of these differences occurring by chance is small –less than 5%. In other words, if we repeated this analysis 100 times, we are likely to find differences of similar magnitude at least 95 out of 100 times.

References

- Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity in the United States, 2009–2010. *NCHS data brief*, no 82. Hyattsville, MD: National Center for Health Statistics. 2012.
- Guo SS, Chumlea WC. Tracking of body mass index in children in relation to overweight in adulthood. *Am J Clin Nutr*. Jul 1999;70(1):145S-148S.
- National Institutes of Health. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults - The evidence report. *Obes Res* 6 (Suppl 2): 51S–209S. 1998.
- Child Health Data Lab. Lurie Children's Research Center. Bullying and Body Weight. *Illinois Youth Risk Behavior Survey*. Issue 9. February 3.
- Trasande L, Chatterjee S. The impact of obesity on health service utilization and costs in childhood. *Obesity*. 009; 17:1749–54).

For more information

Visit www.cookcountypublichealth.org.



2010-2012

School Day Physical Activity Among School-Aged Children in Suburban Cook County, Illinois

Introduction

Overweight and obesity among children is a major public health concern in suburban Cook County (SCC). A recent comparison between national and SCC overweight and obesity prevalence rates by grade specific age groups found SCC rates to be significantly higher. For example, 40% of 9th graders in SCC are already overweight or obese compared to 32% in the U.S. Disparities in overweight and obesity prevalence are also found among regions within SCC where the West and Southwest regions have significantly higher rates.¹

Physical activity (PA), along with proper nutrition, is important in preventing obesity. In addition, PA has many other benefits for children's health and development, such as building and maintaining strong bones and muscles and promoting social and emotional well-being^{2,3}. It further has been linked to improved academic performance.⁴

The Centers for Disease Control and Prevention recommends that children engage in at least one hour of moderate to vigorous physical activity (MVPA) daily to gain health benefits. Moderate PA includes activities such as fast walking; whereas vigorous PA includes activities such as running. Since most U.S. children and youth spend almost half their waking day in school, providing PA opportunities in school settings has the potential to impact the health of most school-aged children and youth. If PA were distributed equally throughout non-sleep hours, we would expect school-aged children and youth in school to engage in at least 28 minutes or 46% of their daily MVPA during a typical 6.5 hour school day.

To better understand opportunities for school-based PA interventions that support obesity prevention, the Cook County Department of Public Health collaborated with the Consortium to Lower Obesity in Chicago Children at Ann and Robert H. Lurie Children's Hospital of Chicago to assess school day PA in a sample of 5th and 6th grade students in selected SCC public elementary schools. This brief shares key findings and recommendations for future efforts.

What was done

Data on PA during the school day were collected for 1,093 children from two classrooms (either 5th or 6th grade) in each of 14 SCC public schools during the spring of school years 2010-11 and 2011-12. Participating students wore accelerometers, which measured PA including time and intensity, for four consecutive school days.

Accelerometer data were categorized by intensity and time spent in PA by intensity level over the course of the school day was summarized for each of the four days. In addition, data were collected on PA opportunities including physical education classes (PE), in-class PA breaks and recess offered on the days on which accelerometer data were collected.

Summary of Key Findings

1

SCC 5th and 6th grade students did not get the expected 28 minutes of physical activity during the school day.

2

SCC students at schools with high proportions of minority students had less time for physical activity.

3

Students' daily average MVPA minutes varied by PA opportunities offered by grade and gender.



Acknowledgements

Made possible by cooperative agreements from the Centers for Disease Control and Prevention (Grant Numbers: 1U58DP002623-01 and 3U58DP002623-01S1) to the Public Health Institute of Metropolitan Chicago (PHIMC) and the Cook County Department of Public Health (CCDPH).

1

Key Finding

SCC 5th and 6th grade students in the sample did not obtain the expected amount of MVPA (28 minutes) during the school day.

The types of PA opportunities offered in SCC public schools included in the sample varied and included PE classes, recess, and in-class PA breaks. All schools in the sample provided some combination of these opportunities, though not all schools provided all types of PA opportunities. On average, 5th and 6th grade students in the sample had 14 minutes of MVPA during the school day. This is half of the expected school day MVPA.

2

Key Finding

Students in schools with high proportions of minority students had less school day MVPA time.

- Students in Hispanic majority schools in the sample had less than half the daily MVPA minutes of students in schools in the sample with a majority of white students (9.8 vs. 21.2 minutes).
- Students in Black majority schools in the sample had 67% fewer daily MVPA minutes than students in schools in the sample with majority of white students (14.2 vs. 21.2 minutes).

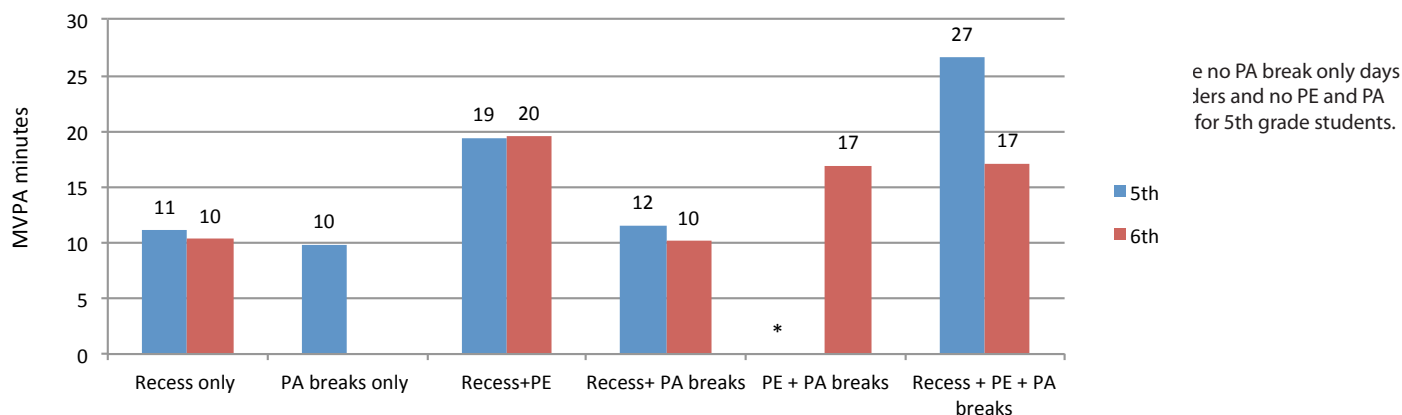
3

Key Finding

Students' daily average MVPA minutes varied by the combination of PA opportunities offered by grade and gender.

- By Grade** (for a visual comparison of MVPA minutes by grade, see Chart 1 below)
 - 6th grade students in the sample had the most daily minutes of MVPA (20 minutes) on school days which included recess and PE.
 - 5th grade students in the sample had the most daily minutes of MVPA time (27 minutes) on school days with a combination of recess, PE and in-class PA breaks PA opportunities.

Chart 1 | Comparison of 5th and 6th Grade Students' School-Day Daily MVPA Minutes by PA Opportunity Combinations

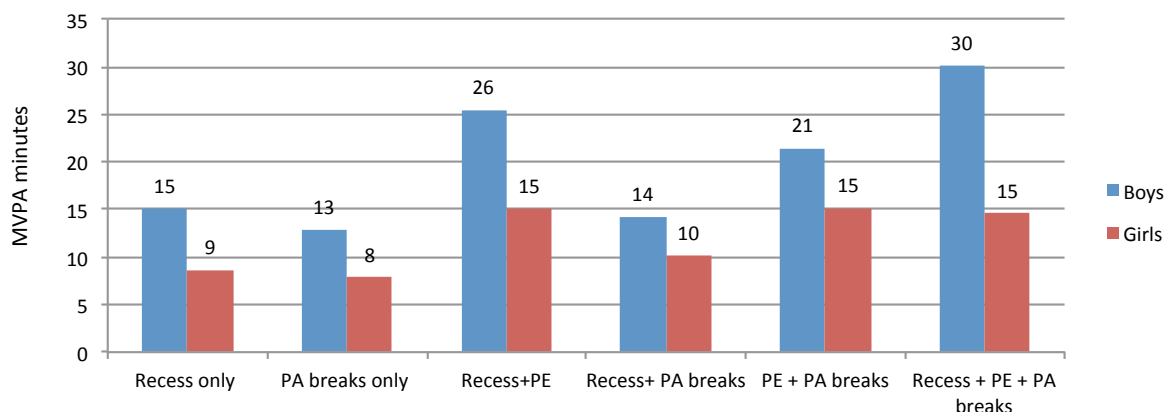


School Day Physical Activity Among School-Aged Children in Suburban Cook County, Illinois

► By Gender (for a visual comparison of MVPA minutes by gender, see Chart 2 below)

- Boys in the sample acquired the expected MVPA during the school day with a combination of recess, PE and PA breaks; whereas there was no combination of PA opportunities offered that resulted in girls in the sample meeting the expected MVPA during the school day.
- There was no increase in daily MVPA minutes for girls in the sample on days when PA breaks were added to recess and PE combinations. On days when only recess or PA breaks were offered, girls in the sample had the least amount of daily MVPA minutes.

Chart 2 | Comparison of Boys' and Girls' School-Day Daily MVPA Minutes by PA Opportunity Combinations



Recommendations

PA provides numerous health benefits including obesity prevention. PA has also been shown to contribute to academic achievement even when time for PA decreases instructional time⁴. Given the benefits of PA and the relatively low proportion of school day time spent in MVPA among students in the sample, the findings point to the following recommendations.

- Schools should assess current PA opportunities offered to students and increase the opportunities for students to be physically active, especially in schools with high minority enrollment.
- Schools should use a combination of PA opportunities to support students in reaching daily MVPA expected during the school day.
- PA opportunities and their combination should be tailored by grade and gender. In the sample, differences were seen in MVPA achievement by grade and gender based on the combination of PA opportunities offered. To guide the combination of PA offerings, schools should consider gathering student input on preferences for PA opportunities.

References

- Brief Report: 2010-2012 Overweight and Obesity Prevalence Among School-Aged Children in Suburban Cook County, Illinois. September 2013.
- U.S. Department of Health and Human Services. Physical Activity Guidelines Advisory Committee report. Washington, DC: U.S. Department of Health and Human Services, 2008.
- Sothorn MS, Loftin M, Suskind RM, Udall JN, Blecker U. The health benefits of physical activity in children. *European Journal of Pediatrics*. 1999; 158: 271-274.
- Fedewa AL, Ahn S. The effects of physical activity and physical fitness on children's achievement and cognitive outcomes: a meta-analysis. *Res Q Exerc Sport*. 2011; 2(3):521-35.

For more information

Visit www.cookcountypublichealth.org.



Assessment of School Meals in Suburban Cook County, Illinois

Introduction

Overweight and obesity among children is a major public health concern in suburban Cook County (SCC). A recent comparison between national and SCC overweight and obesity prevalence rates by grade specific age groups found SCC rates to be significantly higher. For example, 40% of 9th graders in SCC were overweight or obese compared to 32% of children in the U.S. Disparities in overweight and obesity prevalence are also found among regions within SCC where the West and Southwest regions have significantly higher rates.¹

Obesity is caused by long-term patterns of imbalance between calories consumed and calories burned. Good nutrition, along with physical activity, is important in preventing obesity. Maintaining a healthy weight includes limiting the number of excess calories consumed through calorie-dense, nutrient-poor foods, including foods high in fat and sugar.

Public school districts in SCC participate in the National School Breakfast and Lunch Programs, federally assisted meal programs administered by the U.S. Department of Agriculture (USDA). The USDA provides subsidies to school districts to support school meal programs that meet USDA requirements. School districts set meal prices and are reimbursed by the USDA for meals served. Students from low-income families qualify for free or reduced price meals.

Most U.S. school children consume school meals. School meal participation rates are generally higher among elementary school students, minorities and students from low-income households². Due to the high levels of student participation, school meals offer an excellent opportunity to address consumption of excess calories through reduced availability of high calorie, nutrient-poor foods and increased availability of lower calorie nutrient-rich foods, such as low-fat milk, whole grains, fruits and vegetables.

To better understand opportunities for school meal interventions that support obesity prevention, the Cook County Department of Public Health collaborated with the Consortium to Lower Obesity in Chicago Children at Ann and Robert H. Lurie Children's Hospital of Chicago to assess school meal content, student participation, likability, and consumption in a sample of 5th and 6th grade students in 13 SCC public elementary schools. This brief report shares key findings and recommendations for future efforts.

Summary of Key Findings

1

Calories in an average SCC elementary school lunch exceed USDA national nutrition standards.

2

SCC students' participation in school meals varied by meal and school characteristics.

3

Meal consumption in the sample of SCC students varied by meal and item.



Acknowledgements

Made possible by cooperative agreements from the Centers for Disease Control and Prevention (Grant Numbers: 1U58DP002623-01 and 3U58DP002623-01S1) to the Public Health Institute of Metropolitan Chicago (PHIMC) and the Cook County Department of Public Health (CCDPH).

What was done

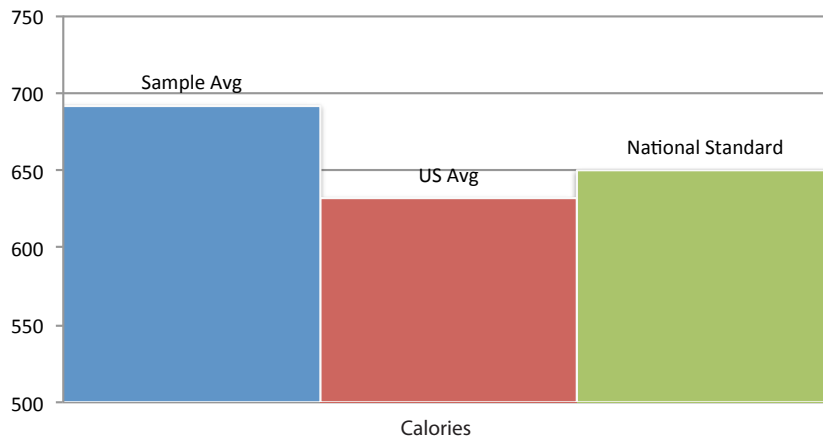
Student school meal participation, likability and consumption data were collected from 1,086 students in two 5th and/or 6th grade classrooms from each of 13 participating SCC public elementary schools. Using a student school meals questionnaire, data were collected once in school year 2010-11 and again in 2011-12. Data from the questionnaire were highly correlated with school meal sales reported by school food service coordinators. Additionally, nutrition information for each lunch meal served over a one-month period of each school year was collected for each school in the sample.

1 Key Finding

Calories in an average school lunch served at SCC elementary schools in our sample exceeded USDA national nutrition standards for elementary school lunches³.

- ▶ The average SCC school lunch served at schools in our sample has 692 calories; the current national nutrition standard is 550-650 calories for elementary school lunches.

Chart 1 | Comparison of Average School Lunch Calories



2 Key Finding

School meal participation in the sample of SCC students varied by meal and school characteristics.

- ▶ Participation in school lunch is significantly higher than for breakfast. In our sample, the participation rate for school breakfast was 37%, which is the same as the national rate. School lunch participation rates among students in our sample are higher than of the national average – 85% vs. the national rate of 63%. However, it is known that elementary school children have higher school meal participation rates.² Since our sample included only elementary-aged students, it is likely that student participation rates in SCC are lower.
- ▶ Similar to national trends, schools with large minority student enrollment in the sample (>70% non-Hispanic Black or Hispanic) had higher school meal participation rates – 67% for breakfast and 94% for lunch. The higher student participation rates in these sampled schools increases the likelihood that improvements to school meals in these settings will have greater impact by reaching more students.

3

Key Finding**Meal consumption in the sample of SCC students varied by meal and item.**

- ▶ 43% of students in our sample reported consuming half or more of breakfast.
- ▶ 61% of students in our sample reported consuming half or more of lunch.
- ▶ 30% of students in our sample reported eating more than half of vegetables served at either breakfast or lunch – the lowest consumption rate for items we tracked.
- ▶ 60% of students in our sample reported eating more than half of fruits served at either breakfast or lunch – the highest consumption rate for items we tracked.

Recommendations

Schools can play an integral role in improving student health. Because participation is so high, school meals provide a means to offer lower calorie, nutrient-rich foods to many students. The findings point to three key areas for efforts to improve student diets through school meals.

Increase Student Participation

Increased participation in school meals is desirable because, generally, while school meal nutritional qualities need improvement, they offer superior options compared to other available options including lunches brought from home². For example, a USDA study found that students participating in school lunch eat twice as many servings of vegetables as those not participating in school lunch². Furthermore, students who do not participate in school meals programs are more likely to purchase competitive foods, which typically are of lower nutritional quality than school meals³. Additionally, in some studies, participation in school breakfast has been associated with reduced obesity³.



Student participation is also important to ensure the financial stability of the school meal programs and increase local school districts' capacity for including items with higher nutritional quality. The USDA reimburses school districts per meal served. Economies of scale dictate that larger volumes of meals served can be cost effective and enable schools to afford to serve higher quality foods. Therefore, increasing participation can make improving the nutritional quality of school meals more sustainable at the local level³.

Participation in school breakfast among is much lower than participation in school lunch, and the amount of the breakfast meal consumed is lower than for lunch among students in our sample. Consumption of breakfast is important for student health, academic performance and obesity prevention⁴. Given this, promotion of school breakfast and working to increase participation and consumption can have a beneficial impact on the health and wellness of students in SCC.

In schools with high minority populations, a primary challenge may be to increase breakfast participation, as lunch participation is already very high. Challenges to breakfast participation include logistics such as requiring students to arrive at school early and increased staffing needs. Some schools have overcome these issues with Universal Breakfast programs offered to all students in classrooms at the start of the school day.

Reduce Calories in School Meals

Currently, the average school lunch meal served by SCC schools in our sample exceeds the national standard for calories. Aligning school lunch meals with this standard would assist in efforts to reduce excess calories in the diets of our children.

Suggested nutrition guidelines can be found on the websites of

- ▶ Alliance for a Healthier Generation at <http://www.healthiergeneration.org/schools.aspx>
- ▶ HealthierUS School Challenge at <http://www.fns.usda.gov/tn/HealthierUS/index.html>

Increase Appeal of Healthier Items

In terms of meal item specific improvements, our findings suggest school food service operations should focus on improving the appeal of vegetables served as they are the meal component least likely to be consumed by students and are typically low in calories and nutrient dense, making them a good choice for improving dietary quality. Further, the majority of students in our sample report consuming all or most of fruits served in school meals. This is an area of success, and efforts to maintain this consumption should continue.

References

1. Brief Report: 2010-2012 Overweight and Obesity Prevalence Among School-Aged Children in Suburban Cook County, Illinois. September 2013.
2. US Department of Agriculture. School nutrition dietary assessment study-III. Vol II: Student participation and dietary intakes, November 2007. Available at: <http://www.fns.usda.gov/ora/menu/published/cnp/FILES/SNDAlll-Vol2.pdf>.
3. Story, M. (Editor). (2009). The school food environment, children's diets and obesity: findings from the Third School Nutrition Dietary Assessment Study. Journal of the American Dietetic Association, 109(2), Supplement 1.
4. Comparison of Previous and Current Regulatory Requirements under Final Rule "Nutrition Standards in the National School Lunch and School Breakfast Programs" (published January 26, 2012).

For more information

Visit www.cookcountypublichealth.org.



Annual Tuberculosis Surveillance Report 2012



**COOK COUNTY HEALTH
& HOSPITALS SYSTEM**
CCHHS

**Cook County Department
of Public Health**

Promoting health. Preventing disease.
Protecting you.

COOK COUNTY DEPARTMENT OF PUBLIC HEALTH

Terry Mason, MD, FACS
*Chief Operating Officer,
Cook County Department of Public Health*

Demian Christiansen, DSc, MPH
*Assistant Director & Tuberculosis Program Manager,
Communicable Disease Control Unit*

Michael O. Vernon, DrPH
Director, Communicable Disease Control Unit

Copyright Information

All materials contained in this report are in the public domain and may be used and reprinted without special permission; citation as to source, however, is appreciated.

Suggested Citation

Cook County Department of Public Health. *Annual Tuberculosis Surveillance Report, 2012*. Oak Forest, IL 2013.

Cook County Department of Public Health
Protecting the Health and Environment of Suburban Cook County
Affiliate, Cook County Health and Hospitals System
Ram Raju, MD, MBA, FACS, FACHE, CEO, Cook County Health and Hospitals System
Honorable Toni Preckwinkle
President, Cook County Board of Commissioners
President, Cook County Board of Health

Communicable Disease Control Unit
Cook County Department of Public Health
15900 S. Cicero Bldg. E - 3rd Floor
Oak Forest, IL 60452

CONTENTS

ACRONYMS, ABBREVIATIONS & DEFINITIONS	5
---	---

OVERVIEW	6
----------------	---

LIST OF TABLES

Table 1. Number and Rate (per 100,000 population) of Reported Tuberculosis Cases by Selected Public Health Jurisdictions, 1993-2012	7
---	---

Table 2. Number and Percentage of Reported Tuberculosis Cases by Selected Characteristics, Suburban Cook County, 2003-2012.....	8
---	---

Table 3. Tuberculosis Cases by Most Frequently Reported Countries of Origin, Suburban Cook County, 2003-2012.....	9
---	---

Table 4. Number and Proportion of Reported Tuberculosis Cases by Site of Disease and Laboratory Results, Suburban Cook County, 2012	10
---	----

Table 5. Tuberculosis Susceptibility Results by Birthplace, Suburban Cook County, 2012	10
--	----

Table 6. Trends in the Number of Reported Tuberculosis Cases, HIV Testing and Coinfection with HIV, Suburban Cook County, 2003-2012.....	11
--	----

Table 7. Reported Tuberculosis Case Rates (per 100,000 population) by Municipality and District, Cook County, 2012	13
--	----

LIST OF FIGURES

Figure 1. Rates of Reported Tuberculosis Cases by Selected Jurisdictions, 1993-20127

Figure 2. Proportion of Reported Tuberculosis Cases by Birthplace, Suburban Cook County, 2003-2012.....8

Figure 3. Reported TB Cases by Birthplace and Race/Ethnicity, Suburban Cook County, 2012.....9

Figure 4. Number of Years Living in the United States Prior to Receiving a Diagnosis of
Active Tuberculosis, Suburban Cook County, 201210

Figure 5. Mode of Treatment Administration in Reported Tuberculosis Cases,
Suburban Cook County, 2003-2012.....11

Figure 6. Completion of Tuberculosis Therapy, Suburban Cook County, 2001-2010.....12

TECHNICAL NOTES14

ACRONYMS, ABBREVIATIONS & DEFINITIONS

Active TB: (see TB Disease)

BCG: Bacille Calmette Guérin, a vaccination given to persons, usually infants, in countries where TB is common. BCG is NOT used in the United States.

Extrapulmonary TB: A person with *Mycobacterium tuberculosis* infection outside of the lungs, the pleural space, and the larynx (voice box). A person with extrapulmonary disease can also have pulmonary TB (see below).

I-NEDSS: I-NEDSS stands for Illinois-National Electronic Disease Surveillance System. I-NEDSS is a web-based application that establishes a secure and real-time communication link between hospitals, laboratories and other health care providers with state and local health department staff for the purposes of reporting and managing communicable disease information. All TB cases in suburban Cook County are reported to the Illinois Department of Public Health using I-NEDSS.

LTBI: Latent Tuberculosis Infection; a person with TB infection who is not contagious.

MDR-TB: Multi-drug resistant TB. MDR-TB is defined as TB resistant to isoniazid and rifampin, the two most important first line anti-tuberculosis medications.

Pulmonary TB: A person with *Mycobacterium tuberculosis* infection of the lungs, pleural space or the larynx (voice box). A person with pulmonary TB can also have extrapulmonary TB.

QFT-G: QuantiFERON-TB Gold Test, a blood test used to detect *Mycobacterium tuberculosis*. This test cannot distinguish persons with LTBI from persons with TB disease. In contrast to the TST (see below), QFT-G can distinguish persons with either LTBI or TB disease from persons who may have received BCG vaccination. QFT-G has greater specificity than TST.

TB: Tuberculosis

TB Disease: A person with TB infection who is contagious to others; a person with TB disease can have pulmonary TB, extrapulmonary TB, or both.

TST: Tuberculin Skin Test, a test whereby purified protein derivative (PPD) is injected under the skin in the forearm. Persons with TB infection react to the PPD which results in a bump (induration) where the PPD was injected. Qualified healthcare personnel can measure the size of the bump and determine whether the test is positive or negative. A positive TST can indicate active TB infection, LTBI, or prior BCG vaccination. However, the TST is not able to distinguish between these three possibilities.

XDR-TB: Extensively drug resistant TB. XDR-TB is defined as MDR-TB plus TB that is resistant to any fluoroquinolone plus resistance to one of the three injectable drugs (i.e., amikacin, kanamycin, or capreomycin).

OVERVIEW

Epidemiologic Summary

- Eighty nine (89) new cases of TB were reported in suburban Cook County in 2012. This represents a rate of 3.6 cases per 100,000 population, a 20% increase in cases reported in 2011 (Table 1).
- The North District had the highest TB rate (5.9 per 100,000 population) of any of the four public health districts in suburban Cook County (Table 7).
- Municipalities with the highest numbers of cases included Des Plaines (n=10) and Skokie (n=8; Table 7). Each of the following municipalities had four (4) TB cases: Alsip, Glenview, Harvey, Morton Grove and Niles (Table 7).

TB Burden in Foreign-born Persons

- The proportion of TB cases in foreign-born persons was 71% in 2012 (Figure 2).
- Three countries accounted for 62% of all foreign-born cases: India (n=17; 27%), the Philippines (n=12; 19%) and Mexico (n=10, 16%) (Table 3).
- Among foreign-born persons diagnosed with TB, 71% arrived 5 or more years prior to receiving a diagnosis of TB disease (Figure 4).

Drug Resistance

- In 2012, no case of MDR-TB was identified (Table 5).

Coinfection with HIV

- Five (5) TB cases were coinfectd with HIV (Table 6); these persons are defined, per AIDS case definition, as having AIDS.

Directly Observed Therapy

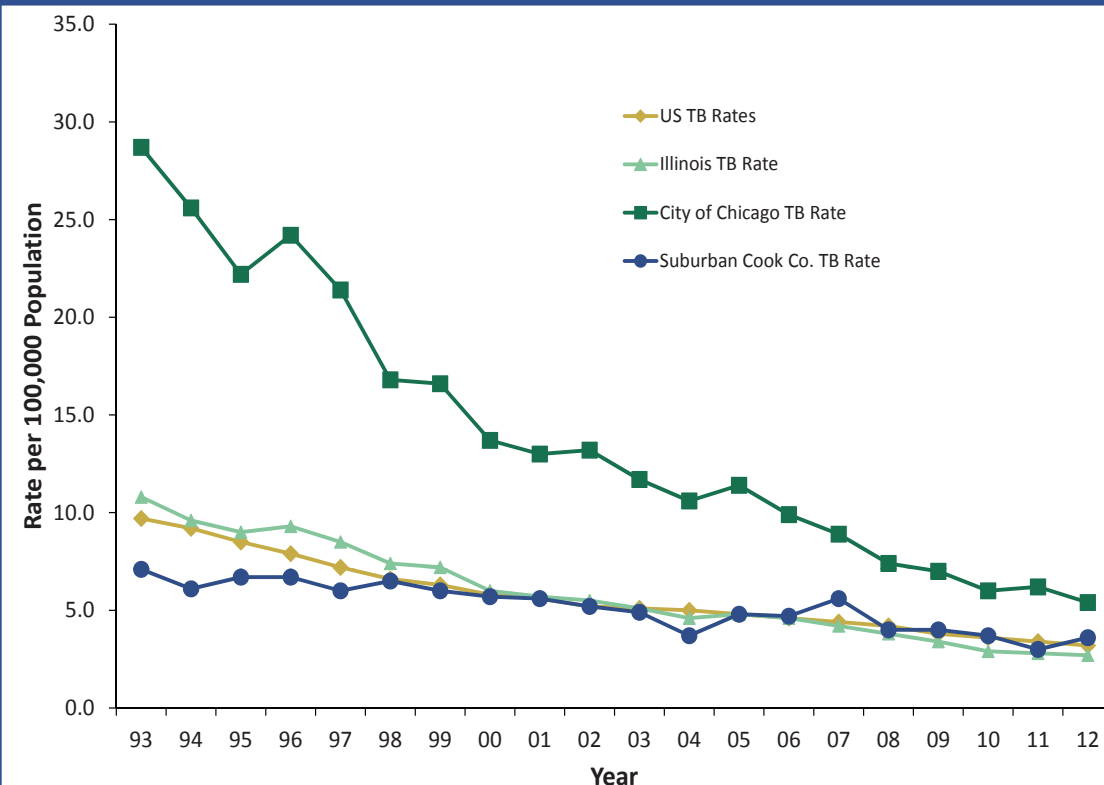
- In 2012, 98% of patients with pulmonary TB received DOT (Figure 5).

Completion of Therapy

- For TB cases diagnosed in 2010, the most recent year for which data on completion of tuberculosis therapy are available, 93% of persons with TB disease who were eligible* completed treatment.
- Among persons diagnosed in 2010 who were eligible* to complete TB treatment in 12 months*, 83% of cases did so. This is below the Healthy People 2020 goal of 93% (Figure 6).

* Eligible cases are persons who were alive at the time of TB diagnosis and did not die during therapy, and excludes persons with TB resistant to rifampin and pediatric cases (<15 years) with a diagnosis of meningeal, bone/joint, or miliary TB.

Figure 1. Rates of Reported Tuberculosis Cases by Selected Jurisdictions, 1993-2012



◀ **Figure 1.** TB rates declined from 7.1 per 100,000 population in 1993 to 3.0 per 100,000 population in 2011. In 2012, the rate increased in suburban Cook County to 3.6 per 100,000. TB rates in Chicago and in Illinois declined to 5.4 and 2.7 per 100,000 population, respectively, in 2012.

Table 1. Number and Rate (per 100,000 population) of Reported Tuberculosis Cases by Selected Public Health Jurisdictions, 1993-2012

Year	Suburban Cook County		City of Chicago		Illinois		USA	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate†
1993	165	7.1	798	28.7	1,235	10.8	25,107	9.7
1994	142	6.1	714	25.6	1,101	9.6	24,205	9.2
1995	155	6.7	619	22.2	1,024	9.0	22,728	8.5
1996	155	6.7	674	24.2	1,060	9.3	21,210	7.9
1997	140	6.0	597	21.4	974	8.5	19,751	7.2
1998	150	6.5	469	16.8	850	7.4	18,287	6.6
1999	140	6.0	463	16.6	825	7.2	17,501	6.3
2000	141	5.7	398	13.7	743	6.0	16,310	5.8
2001	139	5.6	377	13.0	707	5.7	15,945	5.6
2002	130	5.2	382	13.2	680	5.5	15,056	5.2
2003	122	4.9	339	11.7	633	5.1	14,836	5.1
2004	91	3.7	308	10.6	569	4.6	14,500	5.0
2005	120	4.8	329	11.4	596	4.8	14,067	4.8
2006	116	4.7	287	9.9	569	4.6	13,727	4.6
2007	139	5.6	258	8.9	521	4.2	13,288	4.4
2008	100	4.0	214	7.4	469	3.8	12,904	4.2
2009	100	4.0	202	7.0	418	3.4	11,540	3.8
2010	93	3.7	161	6.0	372	2.9	11,181	3.6
2011	75	3.0	166	6.2	359	2.8	10,521	3.4
2012	89	3.6	146	5.4	347	2.7	9,951	3.2

* Rates (per 100,000 population) for years 1993-1999 calculated using 1990 US census data; rates for 2000 - 2009 calculated using 2000 US census data. Rates for 2010-2012 calculated using 2010 US census data.

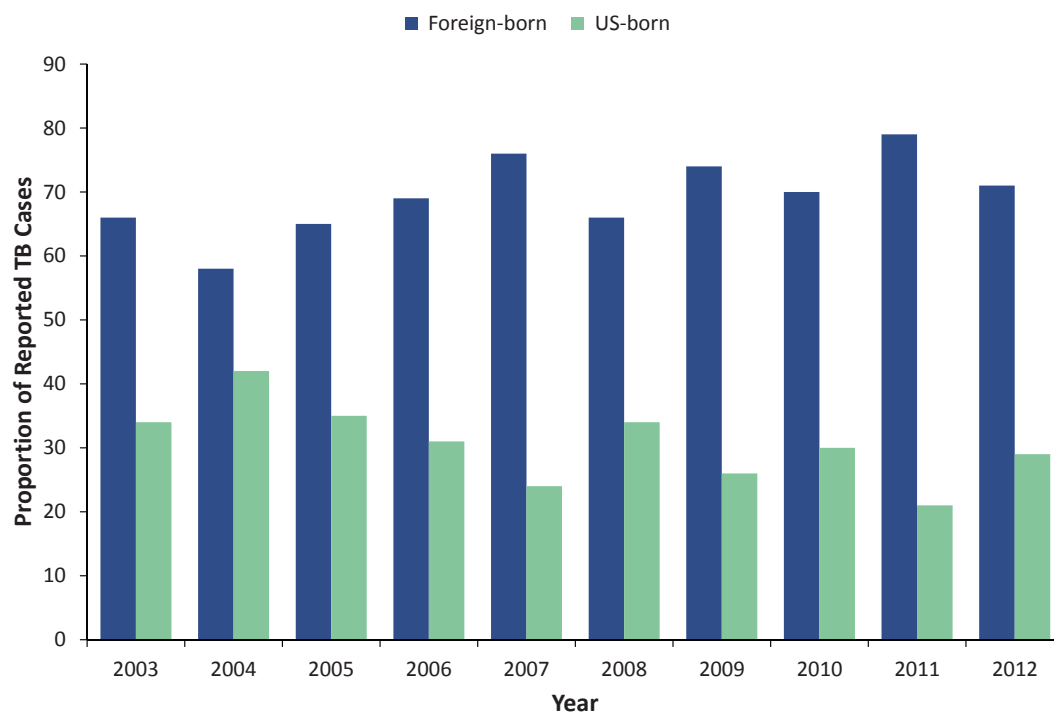
† US rates calculated using intercensal estimates from the US Census Bureau.

Table 2. Number and Percentage of Reported Tuberculosis Cases by Selected Characteristics, Suburban Cook County, 2003-2012

Characteristic	Year																			
	2003		2004		2005		2006		2007		2008		2009		2010		2011		2012	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex																				
Male	70	(57)	53	(58)	57	(48)	64	(55)	73	(52)	58	(58)	47	(47)	51	(55)	41	(55)	50	(56)
Female	52	(43)	38	(42)	63	(53)	52	(45)	67	(48)	42	(42)	53	(53)	42	(45)	34	(45)	39	(44)
Age Groups (Y)																				
<5	1	(1)	1	(1)	3	(3)	4	(3)	3	(2)	2	(2)	2	(2)	2	(2)	1	(1)	4	(4)
5-14	1	(1)	0	(0)	3	(3)	4	(3)	2	(1)	1	(1)	0	(0)	0	(0)	2	(3)	0	(0)
15-24	17	(14)	5	(5)	15	(13)	7	(6)	14	(10)	4	(4)	13	(13)	9	(10)	6	(8)	10	(11)
25-44	38	(31)	31	(34)	43	(36)	36	(31)	32	(23)	40	(40)	40	(40)	24	(26)	24	(32)	18	(20)
45-64	44	(36)	33	(36)	31	(26)	35	(30)	58	(41)	30	(30)	22	(22)	29	(31)	21	(28)	34	(38)
65+	21	(17)	21	(23)	25	(21)	30	(26)	31	(22)	23	(23)	23	(23)	29	(31)	21	(28)	23	(26)
Race/Ethnicity																				
White, not Hispanic	28	(23)	23	(25)	21	(18)	19	(16)	27	(19)	21	(21)	14	(14)	14	(15)	10	(13)	22	(25)
Black, not Hispanic	30	(25)	19	(21)	30	(25)	19	(16)	16	(11)	24	(24)	10	(10)	11	(12)	13	(17)	13	(15)
Hispanic	19	(16)	21	(23)	24	(20)	25	(22)	28	(20)	17	(17)	24	(24)	31	(33)	20	(27)	15	(17)
Asian/Pacific Islander	45	(37)	28	(31)	45	(38)	53	(46)	69	(49)	38	(38)	45	(45)	37	(40)	32	(43)	39	(44)
Other	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)	7	(7)	0	(0)	0	(0)	0	(0)
TOTAL	122	(100)	91	(100)	120	(100)	116	(100)	140	(100)	100	(100)	100	(100)	93	(100)	75	(100)	89	(100)

▲ **Table 2.** In 2012, 56% of TB cases were male; 83% were aged 25 years or older; 44% were Asian/Pacific Islanders. In 2012, there were 4 pediatric cases (i.e. cases <15 years of age) diagnosed in suburban Cook County.

Figure 2. Proportion of Reported Tuberculosis Cases by Birthplace, Suburban Cook County, 2003-2012



◀ **Figure 2.** The proportion of TB cases in foreign-born persons was 71% in 2012.

► **Figure 3.** Important race/ethnicity differences exist in the distribution of cases by birthplace. Among foreign-born persons, Asian/Pacific Islanders accounted for the majority (60%) of cases. By comparison, non-Hispanic Whites accounted for the highest proportion of cases (50%) among U.S.-born TB cases.

Figure 3. Reported TB Cases by Birthplace and Race/Ethnicity, Suburban Cook County, 2012

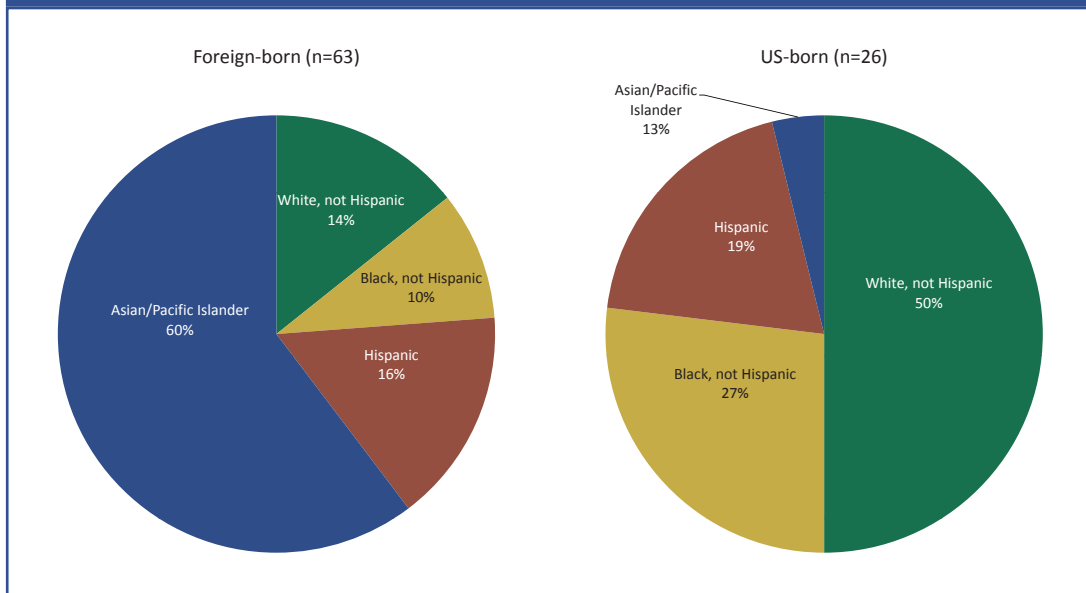


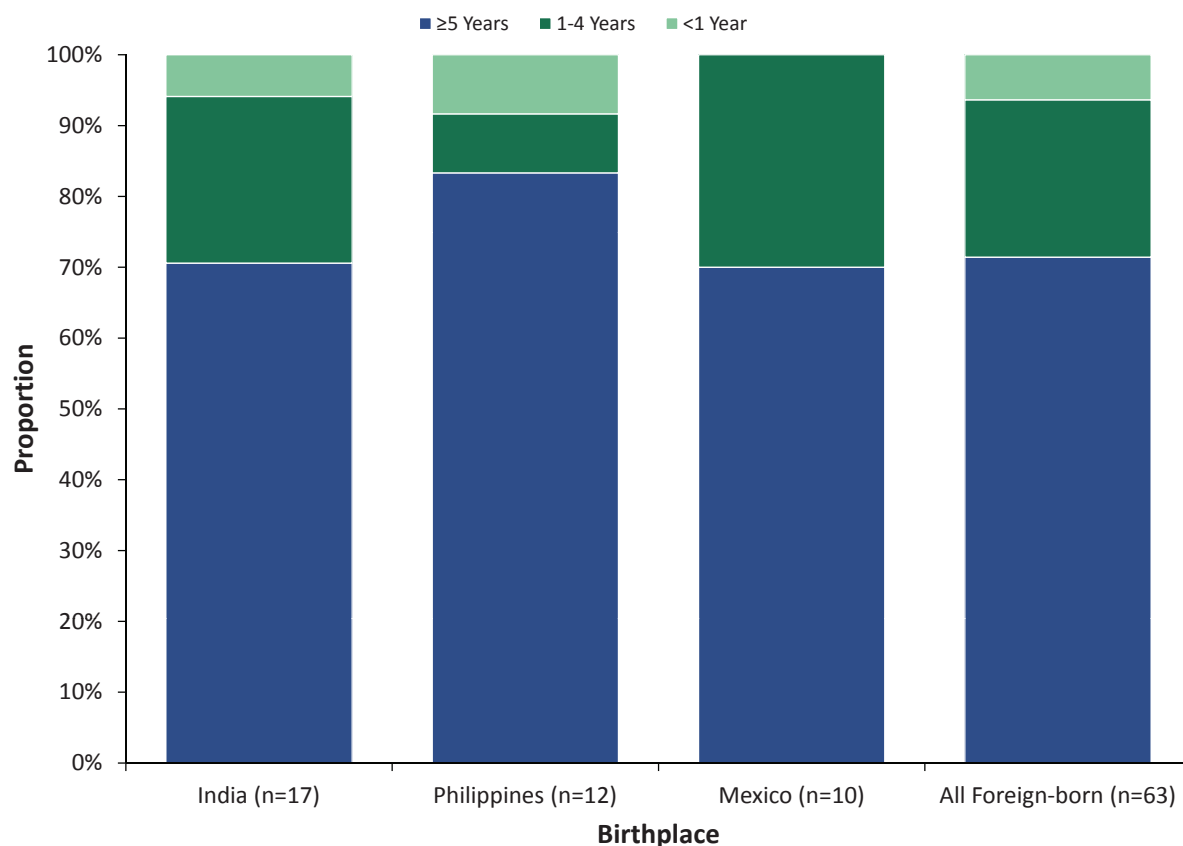
Table 3. Tuberculosis Cases by Most Frequently Reported Countries of Origin, Suburban Cook County, 2003 - 2012

Birthplace	Year									
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012*
India	16	13	24	23	30	10	18	20	18	17
Mexico	14	13	19	18	18	11	17	21	17	10
Philippines	13	10	12	16	21	17	11	8	5	12
Poland	3	3	3	1	4	2	2	1	6	6
Korea South	2	2	4	2	5	1	2	2	1	0
Pakistan	2	1	1	1	5	1	3	0	0	2
China	3	1	0	4	1	4	2	2	0	2
Vietnam	3	0	1	2	1	2	6	1	2	1
Nigeria	4	0	1	0	0	1	1	0	3	0
Haiti	3	0	1	0	1	0	2	0	0	2
Romania	0	1	1	2	0	1	0	0	1	1
Russia	1	0	1	0	1	2	0	1	1	0
Thailand	1	0	0	1	1	0	2	0	0	0
Guatemala	1	1	0	0	2	0	0	0	0	0
Mongolia	0	0	1	2	0	0	0	0	0	3
Myanmar (formerly Burma)	1	0	0	0	1	1	0	0	0	0
Peru	1	1	1	0	2	0	0	1	0	0
Ukraine	1	1	0	0	2	0	0	0	0	0

*Cases were also counted in persons born in Algeria, Bulgaria, Central African Republic, Ethiopia, Germany, Ghana and Indonesia.

◀ **Table 3.** In 2012, 63 foreign-born persons with active TB came from 17 different countries. Three countries of origin accounted for 62% of all foreign born cases: India (n=19; 27%), the Philippines (n=12; 19%) and Mexico (n=10; 16%).

Figure 4. Number of Years Living in the United States Prior to Receiving a Diagnosis of Active Tuberculosis, Suburban Cook County, 2012



◀ **Figure 4.** Among all foreign-born TB cases reported in 2012, 71% arrived in the U.S. 5 or more years prior to receiving a diagnosis of TB disease.

Table 4. Number and Proportion of Reported Tuberculosis Cases by Site of Disease and Laboratory Results, Suburban Cook County, 2012

Site of Disease	Total Cases	Sputum Smear Positive		Culture positive	
	No.	No.	(%)	No.	(%)
Pulmonary Only	55	19	(35)	29	(53)
Extrapulmonary Only	25	0	(0)	0	(0)
Both	9	2	(0)	4	(44)
Total	89	21	(24)	33	(37)

◀ **Table 4.** Fifty five (55) reported TB cases in 2012 had pulmonary only TB; 25 cases had extrapulmonary only TB (no pulmonary involvement). Fifty three percent (53%) of pulmonary only TB cases were culture positive.

► **Table 5.** Fifty nine (59) cases in 2012 had susceptibility testing performed. There were no cases of MDR-TB or XDR-TB in suburban Cook County in 2012.

Table 5. Tuberculosis Susceptibility Results by Birthplace, Suburban Cook County, 2012

Birthplace	Cases with Susceptibility Results	Any Drug Resistance		INH-Resistant		MDR-TB	
	No.	No.	(%)	No.	(%)	No.	(%)
Foreign-born	44	4	(9)	2	(5)	0	(0)
US-born	15	1	(7)	1	(7)	0	(0)
Total	59	11	(19)	4	(7)	0	(0)

► **Table 6.** Testing for HIV among reported cases of TB increased from 73% in 2003 to 88% in 2012. Five (5) cases were coinfecting in 2012. Persons with TB and HIV coinfection are classified, by AIDS surveillance case definition, as having AIDS.

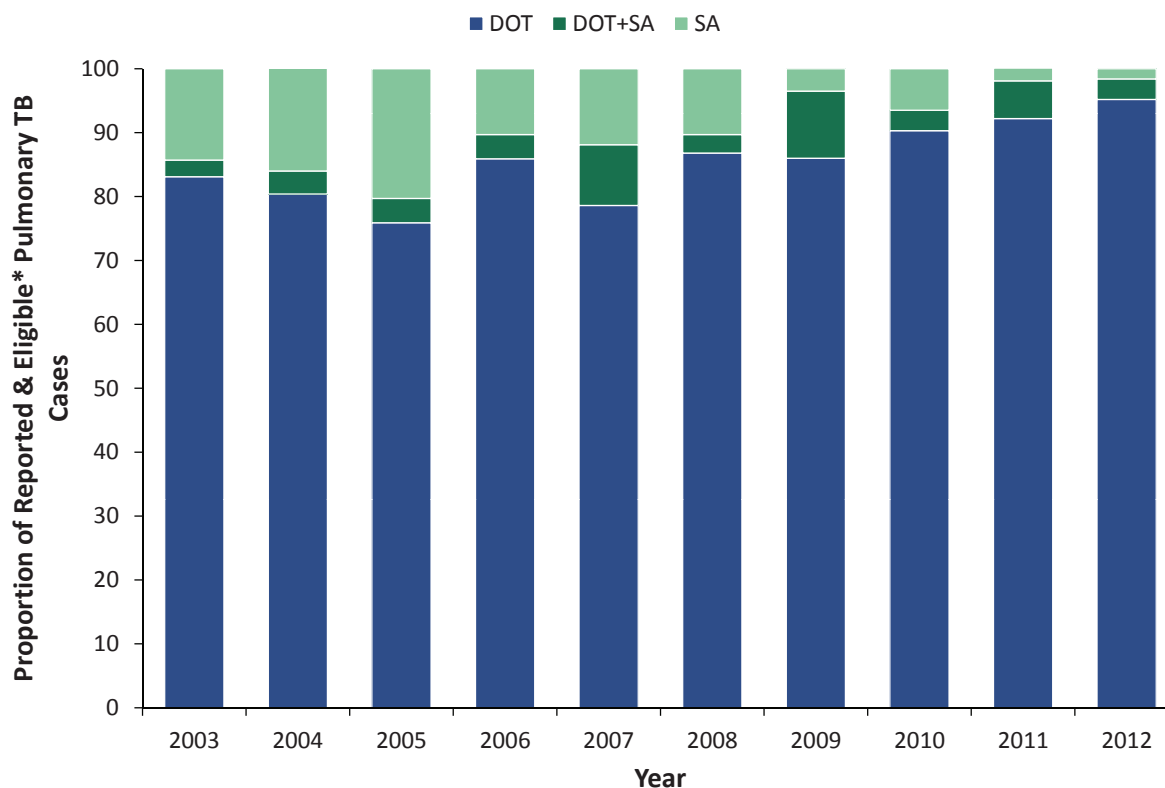
Table 6. Trends in the Number of Reported Tuberculosis Cases, HIV Testing and Coinfection with HIV, Suburban Cook County, 2003-2012

Year	TB Cases	Tested for HIV		Coinfected with HIV*	
	No.	No.	(%)	No.	(%)
2003	122	89	(73)	7	(8)
2004	91	75	(82)	†	†
2005	120	94	(78)	6	(6)
2006	116	85	(73)	†	†
2007	139	109	(78)	6	(6)
2008	100	87	(87)	9	(10)
2009	100	77	(77)	5	(6)
2010	93	72	(77)	0	(0)
2011	75	67	(89)	†	†
2012	89	78	(88)	5	(6)

* Persons with HIV who receive a TB diagnosis are defined as having AIDS.

† Cells with small counts (1-4) have been suppressed.

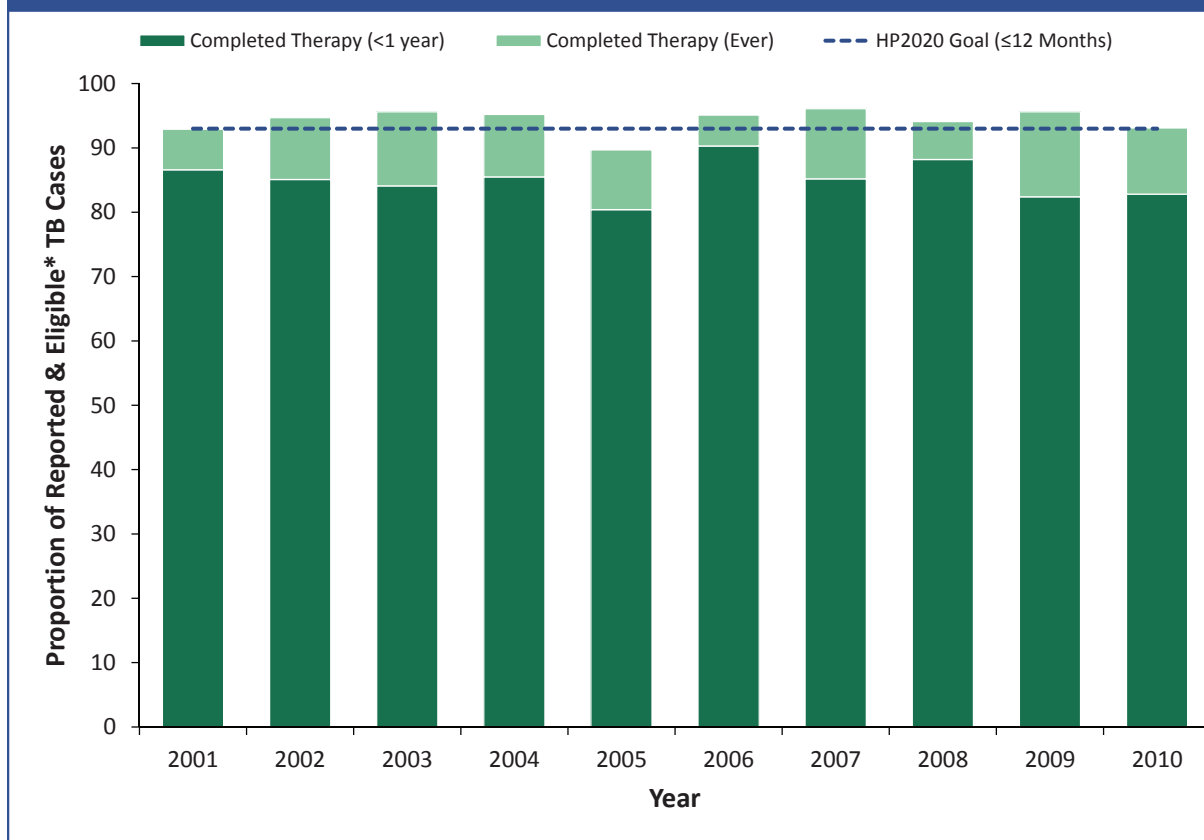
Figure 5. Mode of Treatment Administration in Reported Pulmonary Tuberculosis Cases, Suburban Cook County, 2003-2012



* Percentage includes cases alive at diagnosis, who did not die during therapy with one or more anti-tuberculosis drugs prescribed and excludes persons with missing or unknown information regarding mode of treatment administration.

◀ **Figure 5.** The proportion of TB cases receiving directly observed therapy (DOT), whether DOT only or DOT with some self-administered (SA) therapy has increased over time. The proportion of pulmonary TB cases receiving directly observed therapy (DOT only or DOT+SA) increased from 86% in 2003 to 98% in 2012.

Figure 6. Completion of Tuberculosis Therapy, Suburban Cook County, 2001-2010



◀ **Figure 6.** In 2010, the most recent year for which data on completion of tuberculosis therapy are available, 93% of reported TB cases who were eligible* completed treatment.

In 2010, 83% of eligible* persons completed treatment in less than one year. This is below the Department of Health and Human Services Healthy People 2020 goal of 93%.

* Eligible cases are persons who were alive at the time of TB diagnosis and did not die during therapy, and excludes persons with TB resistant to rifampin and pediatric cases (<15 years) with a diagnosis of meningeal, bone/joint, or miliary TB.

Table 7. Reported Tuberculosis Case Rates (per 100,000 population) by Municipality and District, Suburban Cook County, 2012

NORTH			WEST			SOUTH			SOUTHWEST		
City	No.	Rate	City	No.	Rate	City	No.	Rate	City	No.	Rate
Arlington Heights	1	1.3	Bellwood	0	0.0	Burnham	0	0.0	Alsip	4	20.8
Barrington	1	17.8	Bensenville	0	0.0	Calumet City	2	5.4	Bedford Park	0	0.0
Barrington Hills	0	0.0	Berkeley	1	39.9	Chicago Heights	1	3.3	Blue Island	0	0.0
Bartlett	0	0.0	Berwyn	1	1.8	Country Club Hills	0	0.0	Bridgeview	0	0.0
Buffalo Grove	1	7.3	Broadview	0	0.0	Dixmoor	0	0.0	Burbank	0	0.0
Des Plaines	10	17.1	Brookfield	0	0.0	Dolton	1	4.3	Calumet Park	0	0.0
Elgin	0	0.0	Burr Ridge	0	0.0	East Hazel Crest	0	0.0	Chicago Ridge	0	0.0
Elk Grove Village	1	3.0	Cicero	3	3.6	Flossmoor	0	0.0	Crestwood	0	0.0
Evanston	3	4.0	Countryside	0	0.0	Ford Heights	0	0.0	Evergreen Park	0	0.0
Glencoe	0	0.0	Elmwood Park	0	0.0	Glenwood	0	0.0	Forest View	0	0.0
Glenview	4	9.0	Forest Park	0	0.0	Harvey	4	15.8	Hickory Hills	0	0.0
Golf	0	0.0	Franklin Park	2	10.9	Hazel Crest	0	0.0	Hometown	0	0.0
Hanover Park	1	4.8	Harwood Heights	0	0.0	Homewood	0	0.0	Justice	0	0.0
Hoffman Estates	2	3.9	Hillside	0	0.0	Lansing	0	0.0	Lemont	1	6.3
Inverness	0	0.0	Hinsdale	0	0.0	Lynwood	0	0.0	Merrionette Park	0	0.0
Kenilworth	0	0.0	Hodgkins	0	0.0	Markham	1	8.0	Oak Lawn	0	0.0
Lincolnwood	1	7.9	Indian Head Park	0	0.0	Matteson	0	0.0	Orland Hills	0	0.0
Morton Grove	4	17.2	La Grange	0	0.0	Midlothian	0	0.0	Orland Park	3	5.3
Mount Prospect	3	5.5	La Grange Park	0	0.0	Oak Forest	2	7.2	Palos Heights	0	0.0
Niles	4	13.4	Lyons	0	0.0	Olympia Fields	0	0.0	Palos Hills	2	11.4
Northbrook	1	3.0	Maywood	0	0.0	Park Forest	0	0.0	Palos Park	0	0.0
Northfield	0	0.0	McCook	0	0.0	Phoenix	0	0.0	Stickney	0	0.0
Palatine	0	0.0	Melrose Park	0	0.0	Posen	0	0.0	Summit	0	0.0
Park Ridge	1	2.7	Norridge	0	0.0	Richton Park	0	0.0	Willow Springs	0	0.0
Prospect Heights	0	0.0	North Riverside	0	0.0	Riverdale	1	7.4	Worth	0	0.0
Rolling Meadows	2	8.3	Northlake	1	8.1	Robbins	0	0.0			
Roselle	0	0.0	Oak Park	0	0.0	Sauk Village	0	0.0			
Schaumburg	2	2.7	River Forest	0	0.0	So. Chicago Hts	0	0.0			
Skokie	8	12.3	River Grove	0	0.0	South Holland	1	4.5			
South Barrington	0	0.0	Riverside	0	0.0	Steger	0	0.0			
Streamwood	2	5.0	Rosemont	0	0.0	Thornton	0	0.0			
Wheeling	2	5.3	Schiller Park	0	0.0	Tinley Park	2	4.1			
Wilmette	1	3.7	Stone Park	0	0.0	University Park	0	0.0			
Winnetka	0	0.0	Westchester	1	6.0						
			Western Springs	0	0						
Total	55	5.9	Total	9	1.8	Total	15	3.2	Total	10	2.7

Rates per 100,000 population per year. Rates calculated using 2010 Census data.

Use caution when interpreting rates where the count is < 20.

TECHNICAL NOTES

Surveillance Methodology

Healthcare providers and laboratories in suburban Cook County are required to report the following results within 24 hours: (1) sputum or tissue smears positive for acid-fast bacilli (AFBs); (2) cultures positive for *Mycobacterium tuberculosis*; (3) mycobacterial drug susceptibility results; (4) any other tests positive for *Mycobacterium tuberculosis*. In addition, confirmed TB cases must be reported to CCDPH within 7 days.

TB case reports are entered into I-NEDSS and provide the basis for the information presented in this report. This report includes all cases of tuberculosis reported during the year in which the case was confirmed. Confirmed TB cases who may have moved into suburban Cook County from another jurisdiction are not reflected in the data presented herein; such cases are counted in the jurisdiction that reported the case. Likewise, confirmed TB cases reported in suburban Cook County who may have moved out of suburban Cook County are included in the data presented herein.

Reported TB Case Rates

Suburban Cook County, Chicago and Illinois TB rates between 1993-1999 were calculated using 1990 census data. Suburban Cook County, Chicago and Illinois TB rates between 2000-2009 were calculated using 2000 census data. Suburban Cook County, Chicago and Illinois TB rates after 2009 were calculated using 2010 census data. National TB rates were calculated using national intercensal estimates.

Sexually Transmitted Infections Surveillance Report, 2011



**COOK COUNTY HEALTH
& HOSPITALS SYSTEM**
CCHHS

**Cook County Department
of Public Health**

Promoting health. Preventing disease.
Protecting you.

COOK COUNTY DEPARTMENT OF PUBLIC HEALTH

Terry Mason, MD, FACS

Chief Operating Officer, Cook County Department of Public Health

Demian Christiansen, DSc, MPH

Assistant Director, Communicable Disease Control Unit

Michael O. Vernon, DrPH

Director, Communicable Disease Control Unit

Copyright Information

All materials contained in this report are in the public domain and may be used and reprinted without special permission; citation as to source, however, is appreciated.

Suggested Citation

Cook County Department of Public Health. *Sexually Transmitted Infections Surveillance Report, 2011*. Oak Forest, IL 2013.

Cook County Department of Public Health
Protecting the Health and Environment of Suburban Cook County
Affiliate, Cook County Health and Hospitals System
Ram Raju, MD, MBA, FACS, FACHE, CEO, Cook County Health and Hospitals System
Honorable Toni Preckwinkle
President, Cook County Board of Commissioners
President, Cook County Board of Health

Communicable Disease Control Unit
Cook County Department of Public Health
15900 S. Cicero Bldg. E - 3rd Floor
Oak Forest, IL 60452

CONTENTS

ACRONYMS, ABBREVIATIONS & DEFINITIONS	5
---	---

REPORT HIGHLIGHTS	6
-------------------------	---

LIST OF TABLES

Table 1. Number and Rate (per 100,000 population) of Reported Chlamydia, Gonorrhea and P&S Syphilis Cases by Year, Suburban Cook County, 2007-2011	7
--	---

Table 2. Number, Proportion and Rates (per 100,000 population) of Reported Chlamydia Cases by Selected Characteristics, Suburban Cook County, 2009-2011	9
---	---

Table 3. Number, Proportion and Rates (per 100,000 population) of Reported Gonorrhea Cases by Selected Characteristics, Suburban Cook County, 2009-2011	14
---	----

Table 4. Number, Proportion and Rates (per 100,000 population) of Syphilis and Selected Characteristics of P&S Syphilis Cases, Suburban Cook County, 2009-2011	19
--	----

Table 5. Map Key - Suburban Cook County Municipalities and Chicago Community Areas	22
--	----

LIST OF FIGURES

Figure 1. Trends in the Number of Reported Chlamydia, Gonorrhea and P&S Syphilis Cases Suburban Cook County, 2002-2011	7
--	---

Figure 2. Trends in Chlamydia Rates (per 100,000 population) by Selected Public Health Jurisdictions, 2002-2011	8
---	---

Figure 3. Chlamydia Rates (per 100,000 population) by Sex and Age Groups (Years), Suburban Cook County, 2011	10
--	----

Figure 4. Chlamydia Rates (per 100,000 population) by Race/Ethnicity, Suburban Cook County, 2011	10
--	----

Figure 5. Proportion of Chlamydia Cases Among Persons Aged 15-24 Years by Race/Ethnicity, Suburban Cook County, 2011	11
--	----

Figure 6. Chlamydia Rates (per 100,000 population) by Municipality (Suburban Cook County) or Community Area (Chicago), 2011	12
---	----

Figure 7. Trends in Gonorrhea Rates (per 100,000 population) by Selected Public Health Jurisdictions, 2002-2011	13
---	----

Figure 8. Gonorrhea Rates (per 100,000 population) by Sex and Age Groups (Years),
Suburban Cook County, 201115

Figure 9. Gonorrhea Rates (per 100,000 population) by Race/Ethnicity, Suburban Cook County, 201115

Figure 10. Proportion of Gonorrhea Cases Among Persons Aged 15-24 Years by
Race/Ethnicity, Suburban Cook County, 201116

Figure 11. Average Gonorrhea Rates (per 100,000 population) by Municipality (Suburban Cook County) or
Community Area (Chicago), 2009-201117

Figure 12. P&S Syphilis Rates (per 100,000 population) by Selected Public Health
Jurisdictions, 2002-201118

Figure 13. Proportion of P&S Syphilis Cases by Race/Ethnicity and Year of Report,
Suburban Cook County, 2009-201118

Figure 14. Average P&S Syphilis Rates (per 100,000 population) by Municipality
(Suburban Cook County), or Community Area (Chicago), 2009-201121

ABBREVIATIONS, ACRONYMS & DEFINITIONS

CCDPH: Cook County Department of Public Health. Jurisdiction includes all areas in Cook County, Illinois excluding Chicago, Evanston, Oak Park, Skokie, and Stickney Township.

CDC: Centers for Disease Control and Prevention.

HIV: Human Immunodeficiency Virus, the virus that causes Acquired Immunodeficiency Syndrome (AIDS).

HP2020: Healthy People 2020. A U.S. Health and Human services-sponsored statement of national health objectives aimed at identifying the most significant preventable threats to health and establishing national goals to reduce these threats.

MSM: Male-to-male sexual contact.

P&S SYPHILIS: Primary and secondary stages of syphilis, highly infectious stages.

STI: Sexually Transmitted Infection. Generally, this refers to chlamydia (*Chlamydia trachomatis*), gonorrhea (*Neisseria gonorrhoea*) or syphilis (*Treponema pallidum*) infection.

REPORT HIGHLIGHTS

CHLAMYDIA

- In suburban Cook County, the 2011 chlamydia rate was 370.4 per 100,000 population.
- In 2011, two-thirds of reported chlamydia cases were minorities: 50.4% of cases were non-Hispanic Black and 17.1% were Hispanic.
- The chlamydia rate for non-Hispanic Blacks (1,143.3 per 100,000 population) in 2011 was 16 times higher than the rate in non-Hispanic Whites (70.7 per 100,000 population) and 3.5 times higher than the rate in Hispanics (327.9 per 100,000 population).
- Chlamydia rates among females were 2,272.7 and 1,845.4 per 100,000 population among those aged 20-24 years and 15-19 years, respectively.

GONORRHEA

- In suburban Cook County, the 2011 gonorrhea rate was 91.2 per 100,000 population.
- The average gonorrhea rate in females aged 15-44 years was 246.5 per 100,000 population, lower, overall, than the HP2020 goal of 257.0 per 100,000 population for this age group; however, rates were not uniform and were highest in females aged 20-24 years (609.3 per 100,000 population) and in females aged 15-19 years (571.5 per 100,000 population).
- The average gonorrhea rate in males aged 15-44 years was 205.5 per 100,000 population, slightly higher than the HP2020 goal of 198.0 per 100,000 population for this age group; like females, however, rates were not uniform and were highest in males aged 20-24 years (458.5 per 100,000 population) and in males aged 15-19 (287.8 per 100,000 population).
- The 2011 gonorrhea rate in non-Hispanic Blacks (394.7 per 100,000 population) was 43 times higher than the gonorrhea rate in non-Hispanic Whites (9.1 per 100,000 population) and nearly 15 times higher than the rate in Hispanics (26.8 per 100,000 population).

PRIMARY AND SECONDARY (P&S) SYPHILIS

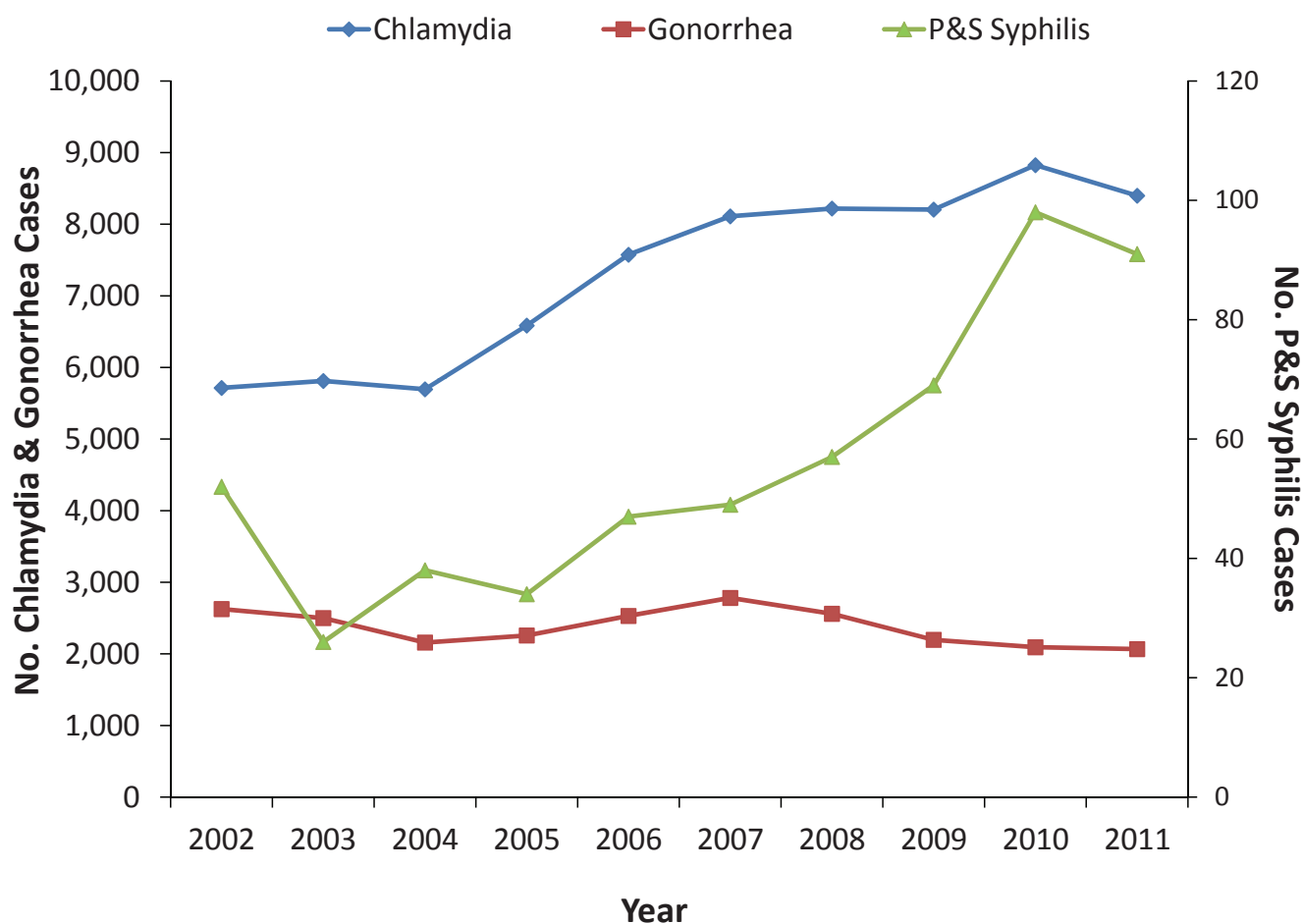
- In suburban Cook County, the 2011 P&S syphilis rate was 4.0 per 100,000 population.
- In 2011, 91.2% of P&S syphilis cases were male, corresponding to a rate of 7.6 per 100,000 population, higher than the HP2020 goal of 6.8 per 100,000 population; the P&S syphilis rate in females was 0.7 per 100,000 population, below the HP2020 goal of 1.5 per 100,000 population.
- In 2011, 70% of reported P&S syphilis cases were non-Hispanic Black; 14.3% were non-Hispanic White and 13.2% were Hispanic.

Table 1. Number and Rate (per 100,000 population) of Reported Chlamydia, Gonorrhea and P&S Syphilis Cases by Year, Suburban Cook County, 2007-2011

Disease	2007		2008		2009		2010		2011		5-Year Median	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Chlamydia	8,110	357.7	8,219	362.5	8,204	361.9	8,825	389.2	8,398	370.4	8,219	362.5
Gonorrhea	2,782	122.7	2,560	112.9	2,196	96.9	2,093	92.3	2,067	91.2	2,196	96.9
P&S Syphilis	49	2.2	57	2.5	69	3.0	98	4.3	91	4.0	69	3.0

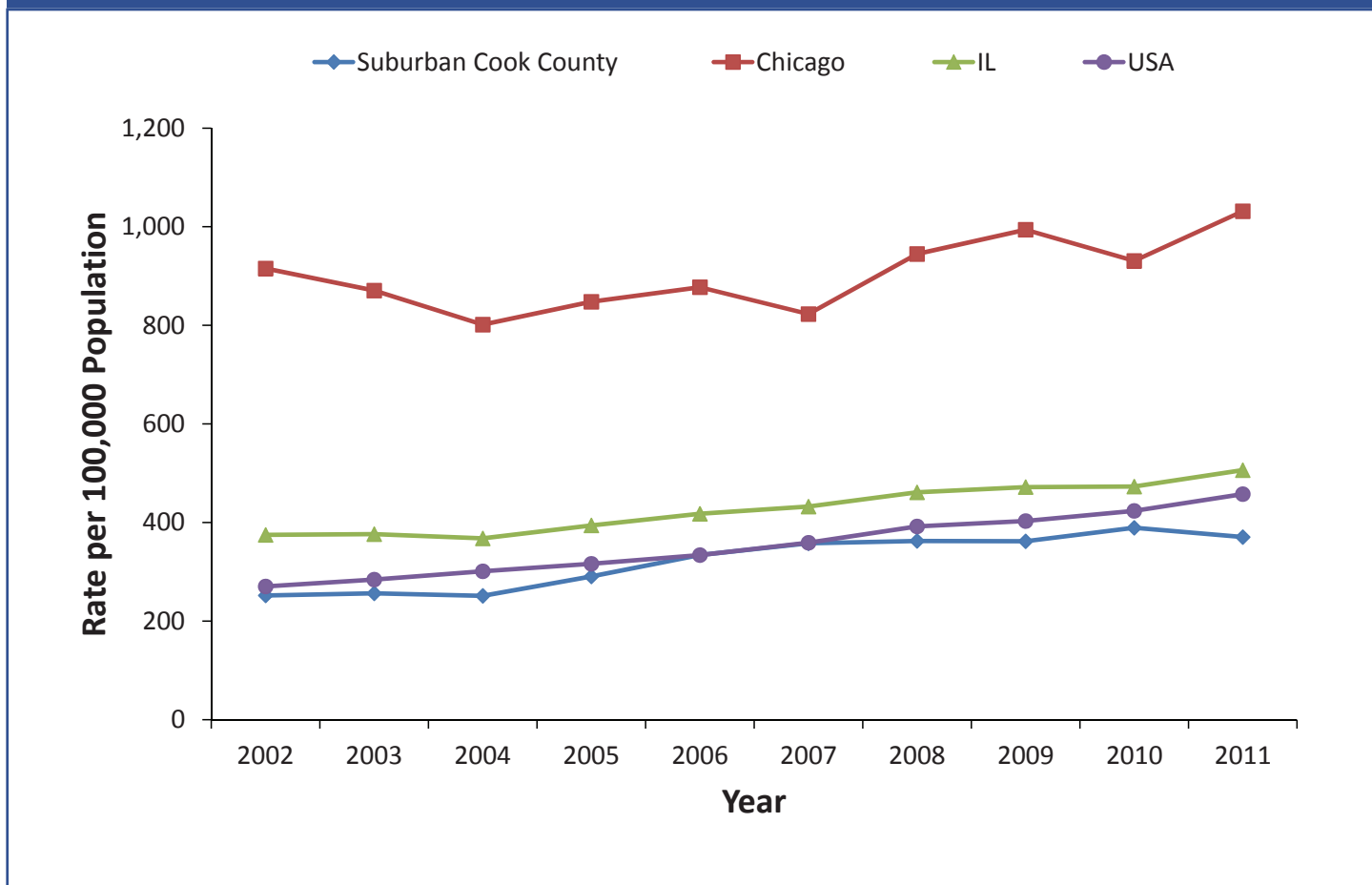
* Incidence rates calculated per 100,000 population based on the 2010 estimate of the population (U.S. Census Bureau).

Figure 1. Trends in the Number of Reported Chlamydia, Gonorrhea and P&S Syphilis Cases, Suburban Cook County, 2002-2011



▲ **Figure 1.** Between 2002-2011, the number of chlamydia cases increased 55%, from 5,695 cases in 2002 to 8,825 cases in 2010. In 2011, 8,398 cases were reported, a 5% decline since the peak in 2010. P&S syphilis cases increased dramatically between 2003 (n=26) and 2010 (n=98), an increase of 277%. P&S syphilis cases declined from 98 in 2010 to 91 in 2011, a 7% decline. Relative to chlamydia and P&S syphilis cases, gonorrhea case reports have been relatively stable between 2002 and 2011. In 2011, 2,067 cases were reported.

Figure 2. Trends in Chlamydia Rates (per 100,000 population) by Selected Public Health Jurisdictions, 2002-2011



▲ **Figure 2.** Rates of chlamydia in suburban Cook County, in Illinois, and in the United States have increased between 2002 and 2011. In 2011, Suburban Cook County had the lowest chlamydia rate, 370.4 per 100,000 population, compared to 457.6 per 100,000 population in the US overall, 506.1 per 100,000 population in Illinois and 1,031.5 per 100,000 population in Chicago.

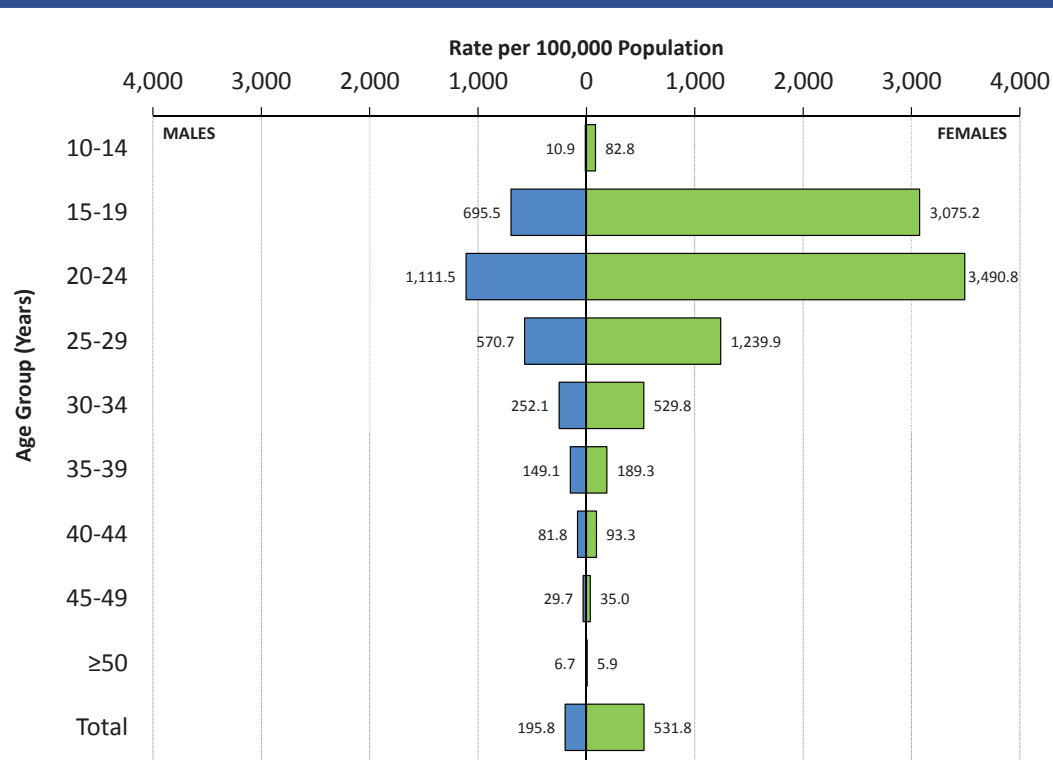
Table 2. Number, Proportion and Rates (per 100,000 population) of Reported Chlamydia Cases by Selected Characteristics, Suburban Cook County, 2009-2011

Characteristic	2009			Year 2010			2011		
	No.	(%)	Rate*	No.	(%)	Rate*	No.	(%)	Rate*
Gender									
Male	1,967	(24.0)	179.5	2,140	(24.2)	195.3	2,145	(25.5)	195.8
Female	6,237	(76.0)	532.4	6,651	(75.4)	532.4	6,230	(74.2)	531.8
Unknown	0	0.0	n/a	34	(0.4)	n/a	23	(0.3)	n/a
Race/Ethnicity									
Non-Hispanic White	864	(10.5)	67.3	867	(9.8)	67.5	908	(10.8)	70.7
Non-Hispanic Black	3,714	(45.3)	1,004.0	4,236	(48.0)	1,145.2	4,229	(50.4)	1,143.3
Hispanic	1,111	(13.5)	254.4	1,279	(14.5)	292.9	1,432	(17.1)	327.9
Asian/Pacific Islander	45	(0.5)	30.0	47	(0.5)	31.4	72	(0.9)	48.1
Other/Unknown	2,470	(30.1)	n/a	2,396	(27.2)	n/a	1,757	(20.9)	n/a
Age Group (Years)									
<10	5	(1.0)	29.2	6	(0.1)	2.0	8	(0.1)	2.7
10-14	86	(34.7)	1,769.8	104	(1.2)	64.6	76	(0.9)	47.2
15-19	2,847	(35.3)	1,805.5	3,150	(35.7)	1,961.8	2,963	(35.3)	1,845.4
20-24	2,899	(15.3)	948.7	3,145	(35.6)	2,379.4	3,004	(35.8)	2,272.7
25-29	1,254	(6.9)	397.6	1,301	(14.7)	907.5	1,305	(15.5)	910.3
30-34	570	(3.1)	178.7	587	(6.7)	414.7	555	(6.6)	392.1
35-39	253	(1.7)	95.4	290	(3.3)	197.6	249	(3.0)	169.7
40-44	140	(1.0)	52.0	107	(1.2)	69.5	135	(1.6)	87.7
45-49	80	(0.9)	41.3	69	(0.8)	40.7	55	(0.7)	32.4
>50	70	(0.9)	9.2	66	(0.7)	8.6	48	(0.6)	6.3
District									
North	1,326	(16.2)	143.0	1,317	(14.9)	142.0	1,342	(16.0)	144.7
West	2,045	(24.9)	405.8	2,085	(23.6)	413.7	2,176	(25.9)	431.8
Southwest	900	(11.0)	247.3	1,064	(12.1)	292.4	814	(9.7)	223.7
South	3,891	(47.4)	824.7	4,339	(49.2)	919.7	4,037	(48.1)	855.7
Unknown	42	(0.5)	n/a	20	(0.2)	n/a	29	(0.3)	n/a
Total	8,204	(100.0)	361.9	8,825	(100.0)	389.2	8,398	(100.0)	370.4

*Incidence rates calculated per 100,000 population based on 2010 estimates of the population (U.S. Census Bureau).

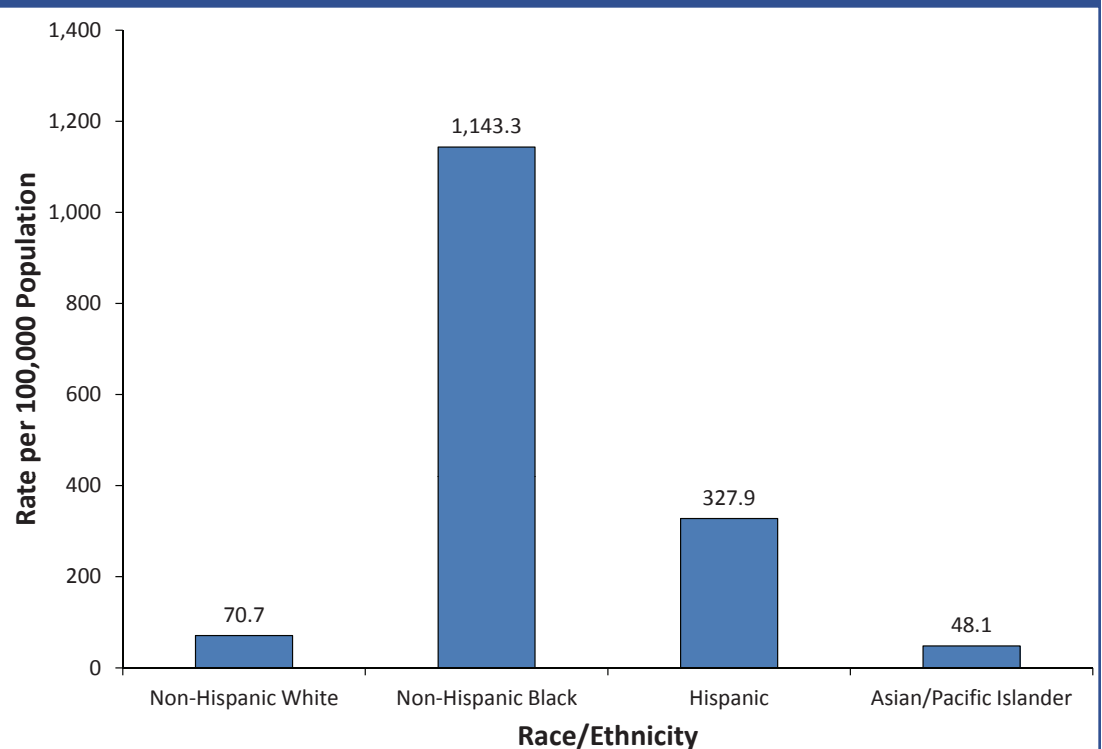
▲ **Table 2. Sex:** Between 2009 and 2011, 75% of reported chlamydia cases were female. **Age Groups:** In 2011 71% of reported chlamydia cases were 15-24 years of age. **Race/Ethnicity:** In 2011, 50.4% of reported chlamydia cases were non-Hispanic Black. In 2011, the rate of chlamydia in non-Hispanic Blacks (1,143.3 per 100,000 population) was 3.5 times higher than the rate in Hispanics (327.8 per 100,000 population) 16 times higher than the rate in non-Hispanic Whites (70.7 per 100,000 population) and 24 times higher than the rate in Asian/Pacific Islanders (48.1 per 100,000 population). **District:** Chlamydia rates were highest in the South District (855.7 per 100,000 population) followed by the West district (431.8 per 100,000 population).

Figure 3. Chlamydia Rates (per 100,000 population) by Sex and Age Groups (Years), Suburban Cook County, 2011



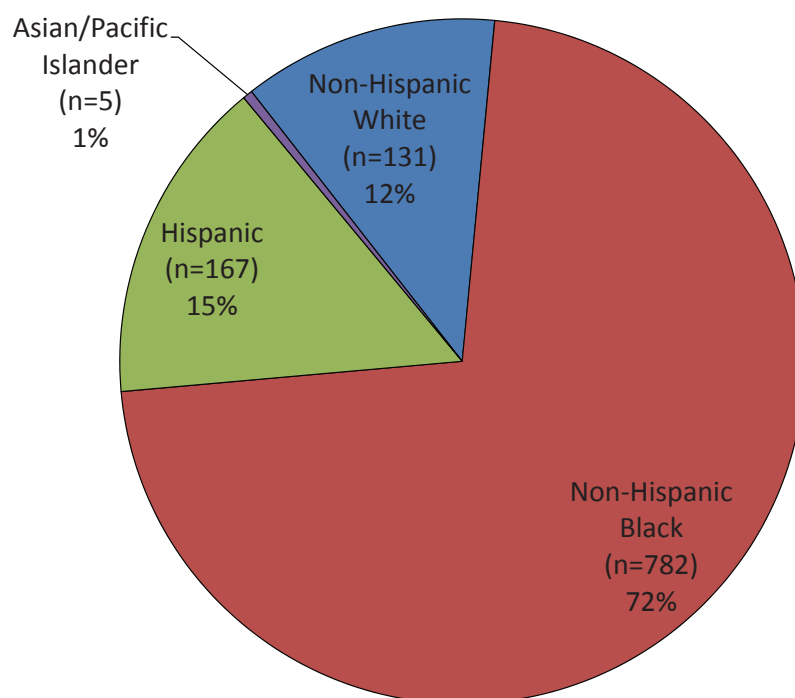
◀ **Figure 3.** The chlamydia rates for both males and females were highest in the 20-24 year old age group followed by those aged 15-19 years of age. However, among those aged 15-19 years of age, the rate in females was 4.4 times greater than the rate in males.

Figure 4. Chlamydia Rates (per 100,000 population) by Race/Ethnicity, Suburban Cook County, 2011



► **Figure 4.** The 2011 chlamydia rate in non-Hispanic Blacks was 3.5 times higher than the rate in Hispanics, 16 times higher than the rate in non-Hispanic Whites, and nearly 24 times higher than the rate in Asian/Pacific Islanders.

Figure 5. Proportion of Chlamydia Cases Among Persons Aged 15-24 Years
by Race/Ethnicity, Suburban Cook County, 2011



▲ **Figure 5.** In 2011, a majority of chlamydia cases reported in youth (persons aged 15-24 years) were non-Hispanic Black (72%); 15% of cases were Hispanic, 12% of cases were non-Hispanic White, and less than 1% of cases diagnosed in 2011 were Asian/Pacific Islanders.

Figure 6. Chlamydia Rates (per 100,000 population) by Municipality (Suburban Cook County) or Community Area (Chicago), 2009-2011

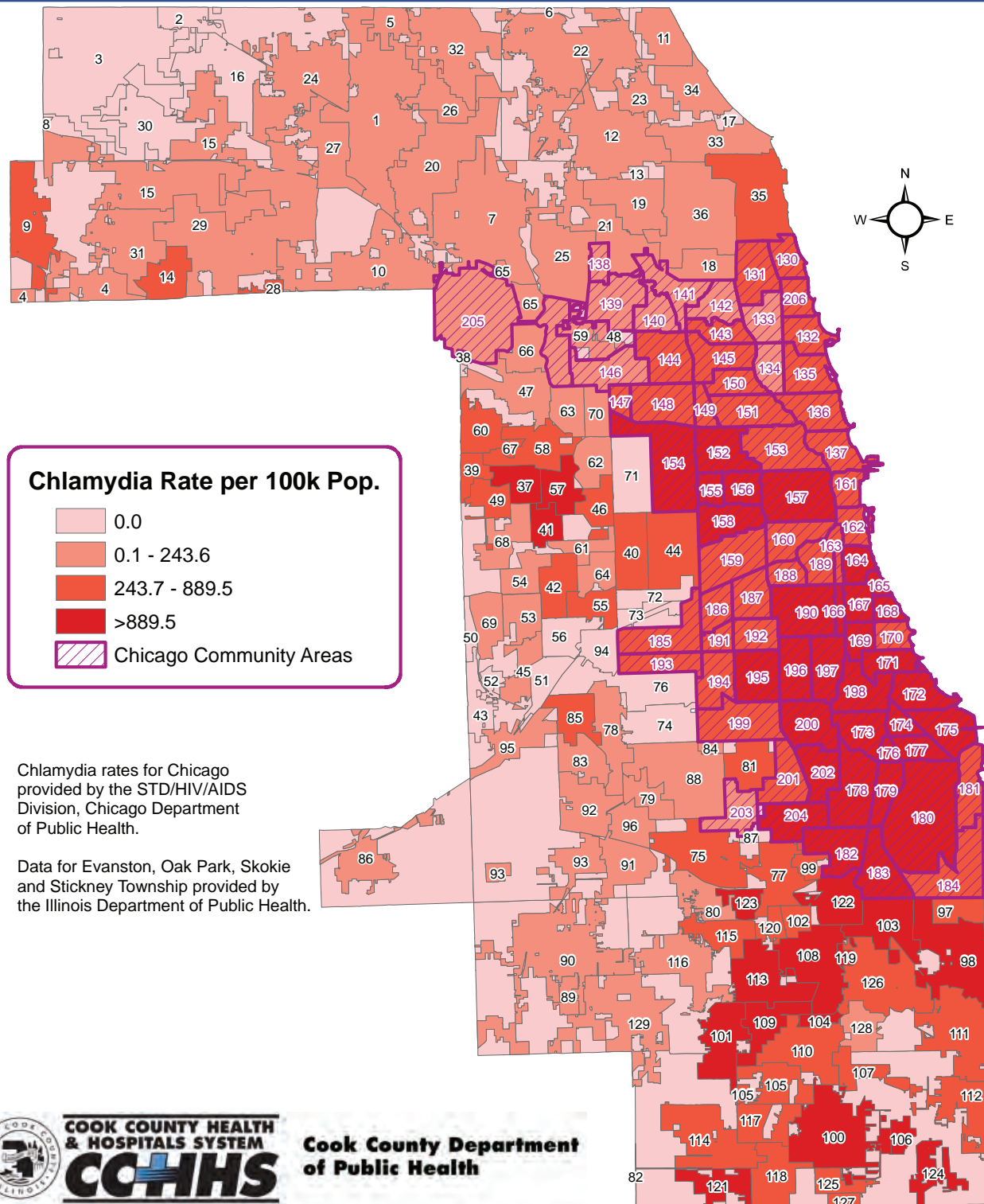
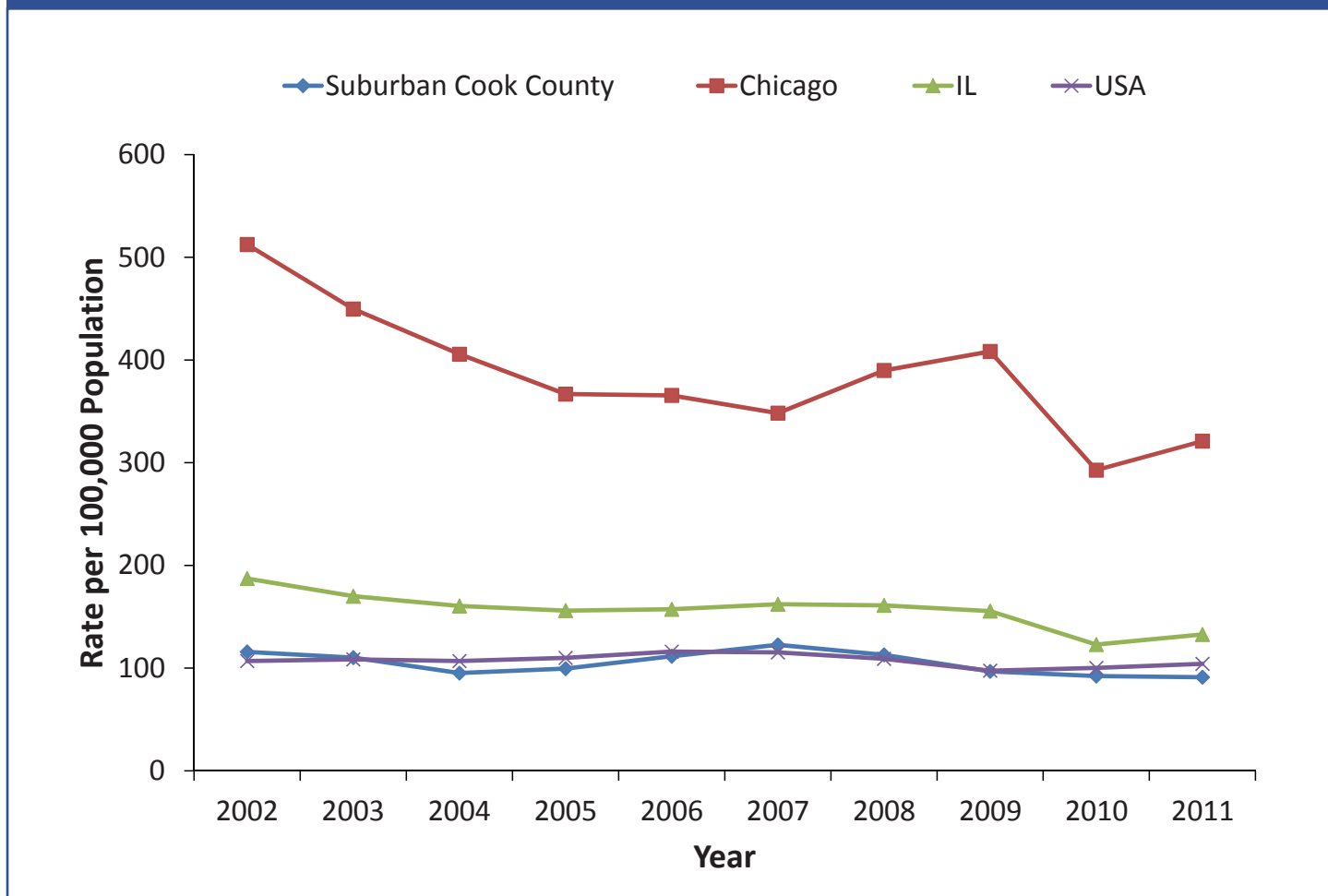


Figure 7. Trends in Gonorrhea Rates (per 100,000 population) by Selected Public Health Jurisdictions, 2002-2011



▲ **Figure 7.** over the past 10 years, gonorrhea rates in suburban Cook County have been relatively constant and were similar to rates in the United States. In 2011, the gonorrhea rate in suburban Cook County was 91.2 per 100,000 population. The rate in the US overall was 104.2 per 100,000 population. The 2011 gonorrhea rates in Illinois and Chicago were 132.8 and 321.1 per 100,000 population, respectively.

Table 3. Number, Proportion and Rates (per 100,000 population) of Reported Gonorrhea Cases by Selected Characteristics, Suburban Cook County, 2009-2011

Characteristic	2009			Year 2010			2011		
	No.	(%)	Rate*	No.	(%)	Rate*	No.	(%)	Rate*
Gender									
Male	971	(44.2)	88.6	914	(43.7)	83.4	944	(45.7)	86.2
Female	1,225	(55.8)	104.6	1,171	(55.9)	100.0	1,117	(54.0)	95.3
Unknown	0	0.0	n/a	8	(0.4)	n/a	6	(0.3)	n/a
Race/Ethnicity									
Non-Hispanic White	139	(6.3)	10.8	136	(6.5)	10.6	117	(6.5)	9.1
Non-Hispanic Black	1,373	(62.5)	371.2	1,346	(64.3)	363.9	1,460	(64.3)	394.7
Hispanic	106	(4.8)	24.3	106	(5.1)	24.3	117	(5.1)	26.8
Asian	4	(0.2)	§	8	(0.4)	5.3	4	(0.4)	§
Other/Unknown	574	(26.1)	n/a	497	(23.7)	n/a	369	(23.7)	n/a
Age Group (Years)									
<10	2	(0.1)	§	1	(0.0)	§	1	(0.0)	§
10-14	25	(1.1)	15.5	30	(1.4)	18.6	21	(1.0)	13.1
15-19	729	(33.2)	454.0	722	(34.5)	449.7	684	(33.1)	426.0
20-24	745	(33.9)	563.6	731	(34.9)	553.0	706	(34.2)	534.1
25-29	314	(14.3)	219.0	291	(13.9)	203.0	333	(16.1)	232.3
30-34	165	(7.5)	116.6	139	(6.6)	98.2	137	(6.6)	96.8
35-39	96	(4.4)	65.4	91	(4.3)	62.0	75	(3.6)	51.1
40-44	49	(2.2)	31.8	40	(1.9)	26.0	56	(2.7)	36.4
45-49	34	(1.5)	20.1	24	(1.1)	14.2	26	(1.3)	15.3
>50	37	(1.7)	4.8	24	(1.1)	3.1	28	(1.4)	3.7
District									
North	161	(7.3)	17.4	151	(7.2)	16.3	146	(7.1)	15.7
West	413	(18.8)	81.9	413	(19.7)	81.9	477	(23.1)	94.6
Southwest	266	(12.1)	73.1	240	(11.5)	66.0	172	(8.3)	47.3
South	1,338	(60.9)	283.6	1,282	(61.3)	271.7	1,261	(61.0)	267.3
Unknown	18	(0.8)	n/a	7	(0.3)	n/a	11	(0.5)	n/a
Total	2,196	(100.0)	96.9	2,093	(100.0)	92.3	2,067	(100.0)	91.2

* Incidence rates calculated per 100,000 population based on the 2010 estimate of the population (U.S. Census Bureau).

§ Rate not calculated for n<5.

▲ **Table 3. Sex:** Between 2009 and 2011, 55% of reported gonorrhea cases were female. **Race/Ethnicity:** in 2011, 64% of gonorrhea cases were in non-Hispanic Blacks; 6.5% were non-Hispanic White and 5.1% were Hispanic. The 2011 gonorrhea rate in non-Hispanic Blacks was 394.7 per 100,000, 43 times higher than the rate in non-Hispanic Whites (9.1 per 100,000 population) and nearly 15 times higher than the rate in Hispanics (26.8 per 100,000 population). **Age Groups:** As with chlamydia, the majority (83.4%) of cases were 15-29 years of age; of these, 80% were aged 14-24 years. **District:** In 2011, 51% of gonorrhea cases were diagnosed in the South District and 23.1% were diagnosed in the West District. The South and West districts also had the highest gonorrhea rates in 2011 (267.3 and 94.6 per 100,000 population, respectively).

► **Figure 8.** As was the case with chlamydia rates, gonorrhea rates were highest in persons aged 15-24 years of age. Females aged 20-24 years of age had the highest gonorrhea rate in 2011 (609.3 per 100,000 population), followed by females 15-19 years of age (571.5 per 100,000 population). The average rate in females aged 15-44 years of age was 246.5 per 100,000 population, lower, overall, than the HP2020 goal of 257.0 per 100,000 population in this age group. Among males, those aged 20-24 years had the highest gonorrhea rate (458.5 per 100,000 population), followed by males aged 15-19 years (287.8 per 100,000 population). The average rate in males aged 15-44 years was 205.5 per 100,000 population, higher, overall, than the HP2020 goal of 198.0 per 100,000 population in this age group.

Figure 8. Gonorrhea Rates (per 100,000 population) by Sex and Age Groups (Years), Suburban Cook County, 2011

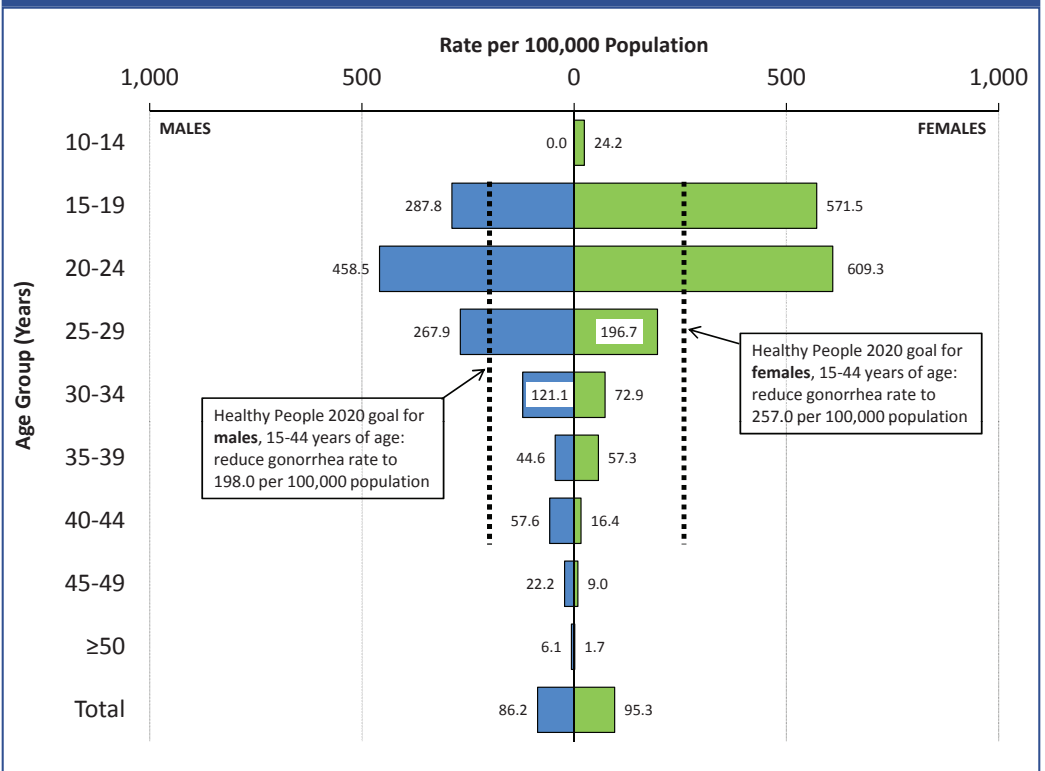
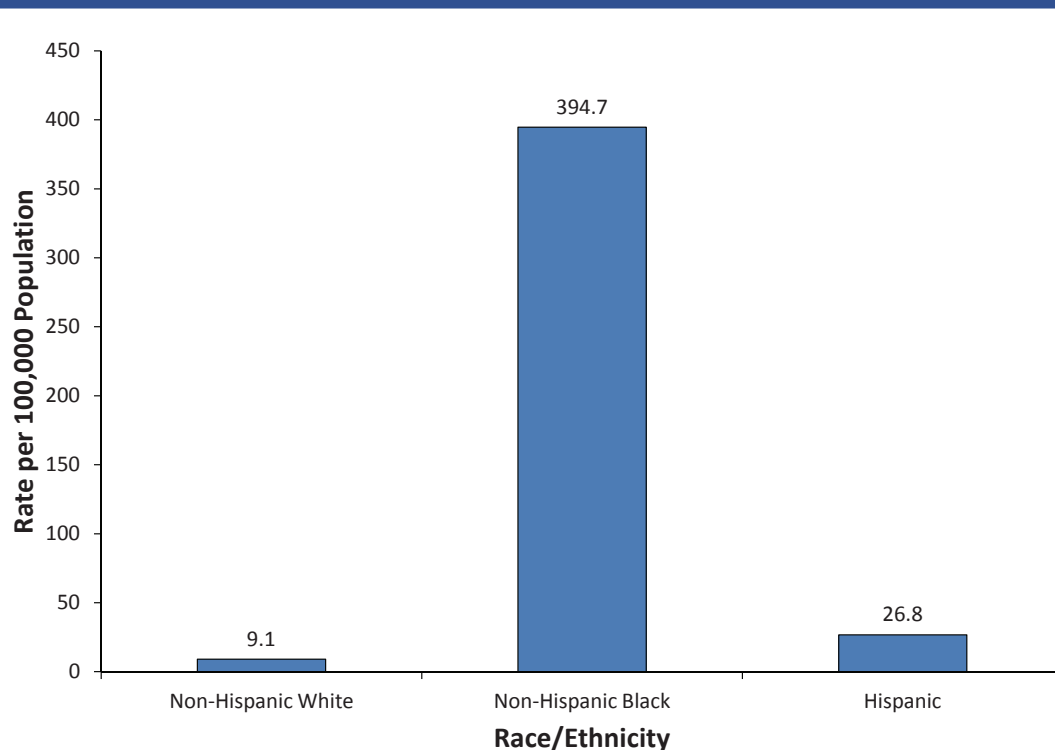
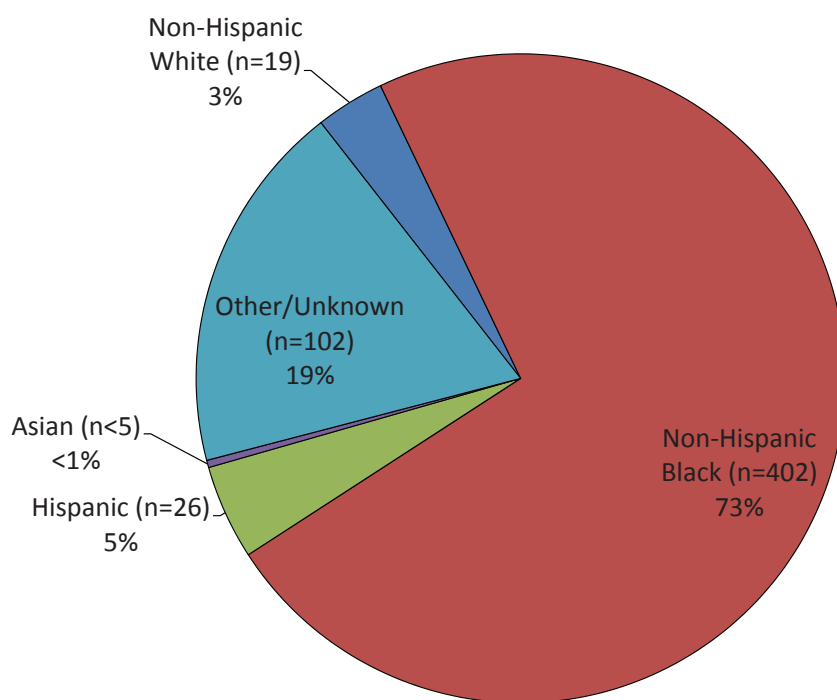


Figure 9. Gonorrhea Rates (per 100,000 population) by Race/Ethnicity, Suburban Cook County, 2011



◀ **Figure 9.** The 2011 gonorrhea rate in non-Hispanic Blacks was 394.7 per 100,000, 43 times higher than the rate in non-Hispanic Whites (9.1 per 100,000 population) and nearly 15 times higher than the rate in Hispanics (26.8 per 100,000 population).

Figure 10. Proportion of Gonorrhea Cases Among Persons Aged 15-24 Years by Race/Ethnicity, Suburban Cook County, 2011



▲ **Figure 10.** Among gonorrhea cases reported in 2011 who were 15-24 years of age, 73% were non-Hispanic Black, 5% were Hispanic, 3% were non-Hispanic White and less than 1% were Asian/Pacific Islanders.

Figure 11. Gonorrhea Rates (per 100,000 population) by Municipality (Suburban Cook County) or Community Area, Chicago, 2011

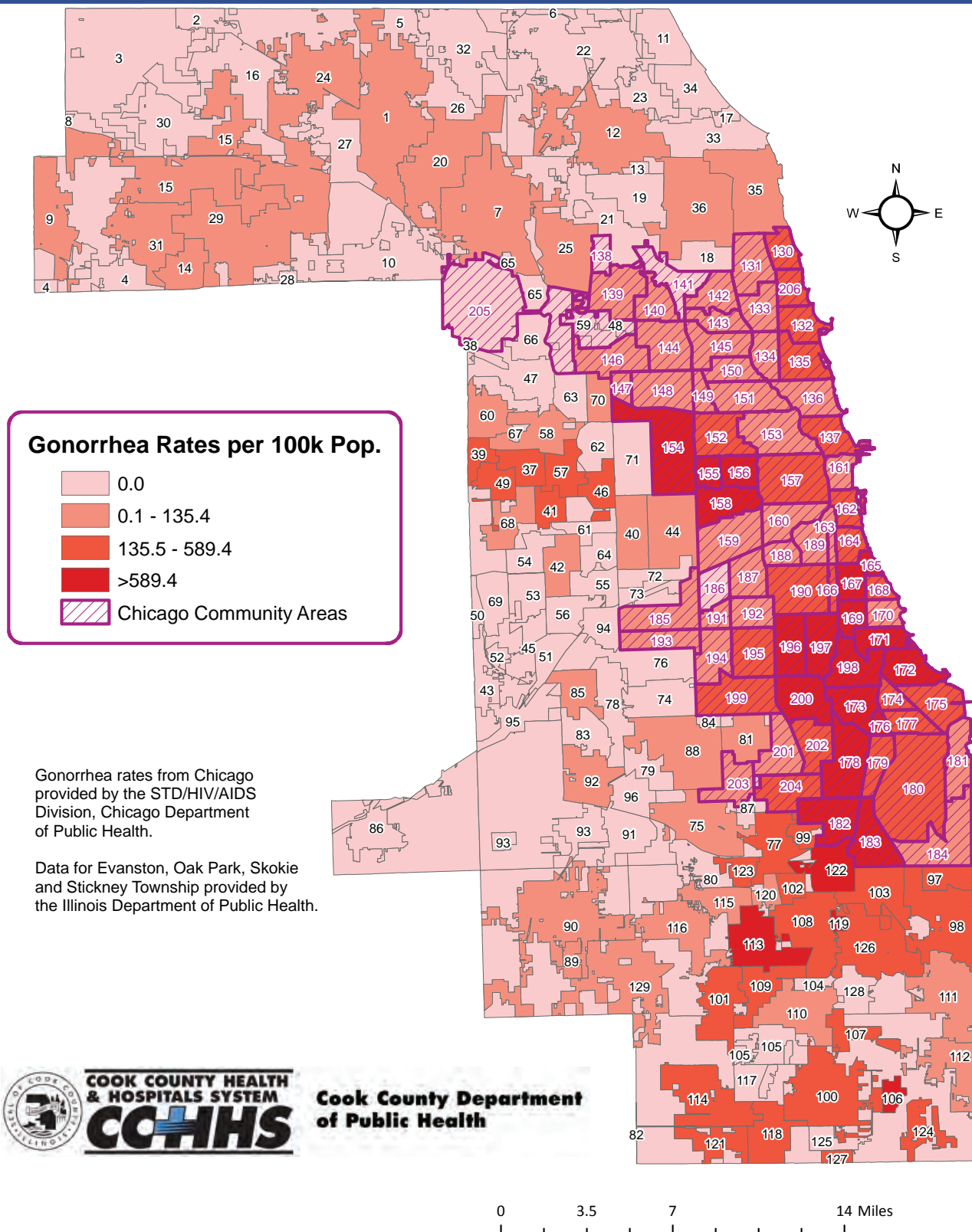
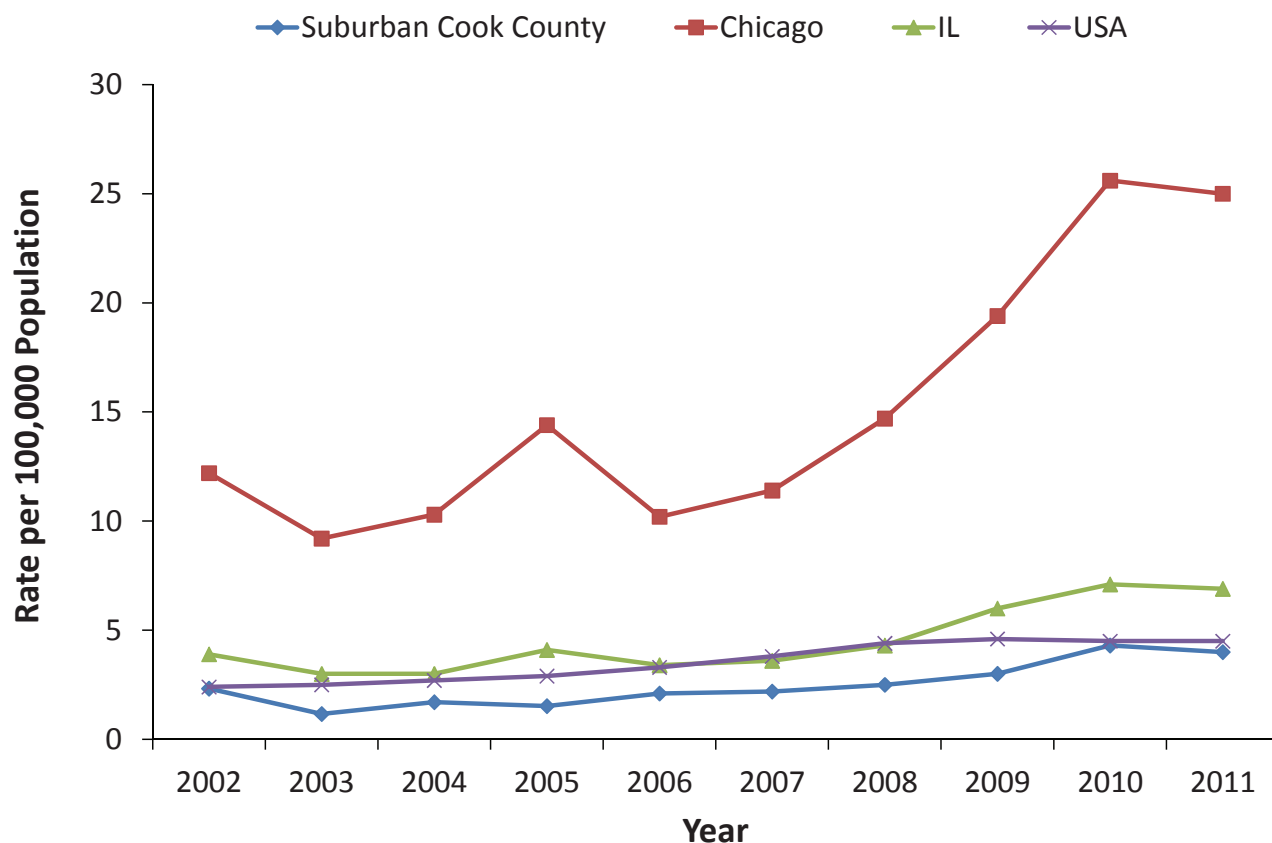


Figure 12. Primary and Secondary Syphilis Rates (per 100,000 population) by Selected Public Health Jurisdictions, 2002-2011



▲ **Figure 11.** Between 2002-2011, rates of primary and secondary (P&S) syphilis in suburban Cook County were typically lower than the rates in the US overall, lower than the rates in Illinois and lower than the rates in Chicago. In 2011, the rate of P&S syphilis in suburban Cook County was 4.0 per 100,000 population. In the US overall, the rate was 4.5 per 100,000 population. The P&S syphilis rate in Illinois was 6.9 per 100,000 population. Chicago had the highest P&S syphilis rate at 25.0 per 100,000 population, 6 times higher than the rate in suburban Cook County. In suburban Cook County and in Chicago, P&S syphilis rates decreased somewhat from 2010 to 2011.

Table 4. Number, Proportion and Rates (per 100,000 population) of Syphilis Cases and Selected Characteristics of P&S Syphilis Cases, Suburban Cook County, 2009-2011

Characteristic	Year								
	2009			2010			2011		
	No.	(%)	Rate*	No.	(%)	Rate*	No.	(%)	Rate*
Syphilis Stage									
Primary and Secondary	69	(31.5)	3.0	98	(41.4)	4.3	91	(34.5)	4.0
Early Latent	64	(29.2)	2.8	53	(22.4)	2.3	80	(30.3)	3.5
Late Latent	83	(37.9)	3.7	80	(33.8)	3.5	86	(32.6)	3.8
Congenital¶	3	(1.4)	§	6	(2.5)	0.3	7	(2.7)	0.3
Total	219	(100.0)	9.7	237	(100.0)	10.5	264	(100.0)	11.6
Primary and Secondary Cases									
Sex									
Male	62	(89.9)	5.7	90	(91.8)	8.2	83	(91.2)	7.6
Female	7	(10.1)	0.6	8	(8.2)	0.7	8	(8.8)	0.7
Race/Ethnicity									
Non-Hispanic White	8	(11.6)	0.6	26	(26.5)	2.0	13	(14.3)	1.0
Non-Hispanic Black	47	(68.1)	3.7	61	(62.2)	4.8	64	(70.3)	5.0
Hispanic	11	(15.9)	0.9	9	(9.2)	0.7	12	(13.2)	0.9
Asian	0	0.0	0.0	2	(2.0)	§	1	(1.1)	§
Other/Unknown	3	(4.3)	§	0	0.0	0.0	1	(1.1)	§
Age Group (in years)									
<20	6	(8.7)	1.0	10	(10.2)	1.6	4	(4.4)	0.6
20-24	15	(21.7)	2.4	24	(24.5)	3.9	25	(27.5)	4.1
25-29	15	(21.7)	2.4	16	(16.3)	2.6	23	(25.3)	3.7
30-34	8	(11.6)	1.3	7	(7.1)	1.1	11	(12.1)	1.8
35-39	4	(5.8)	0.6	13	(13.3)	2.1	7	(7.7)	1.1
40-44	7	(10.1)	1.1	7	(7.1)	1.1	6	(6.6)	1.0
45-49	8	(11.6)	1.3	15	(15.3)	2.4	7	(7.7)	1.1
>50	6	(8.7)	1.0	6	(6.1)	1.0	8	(8.8)	1.3
District									
North	14	(20.3)	1.5	17	(17.3)	1.8	14	(15.4)	1.5
West	17	(24.6)	3.4	28	(28.6)	5.6	25	(27.5)	5.0
Southwest	6	(8.7)	1.6	8	(8.2)	2.2	12	(13.2)	3.3
South	32	(46.4)	6.8	45	(45.9)	9.5	40	(44.0)	8.5
Total P&S Syphilis Cases	69	(100.0)	3.0	98	(100.0)	4.3	91	(100.0)	4.0

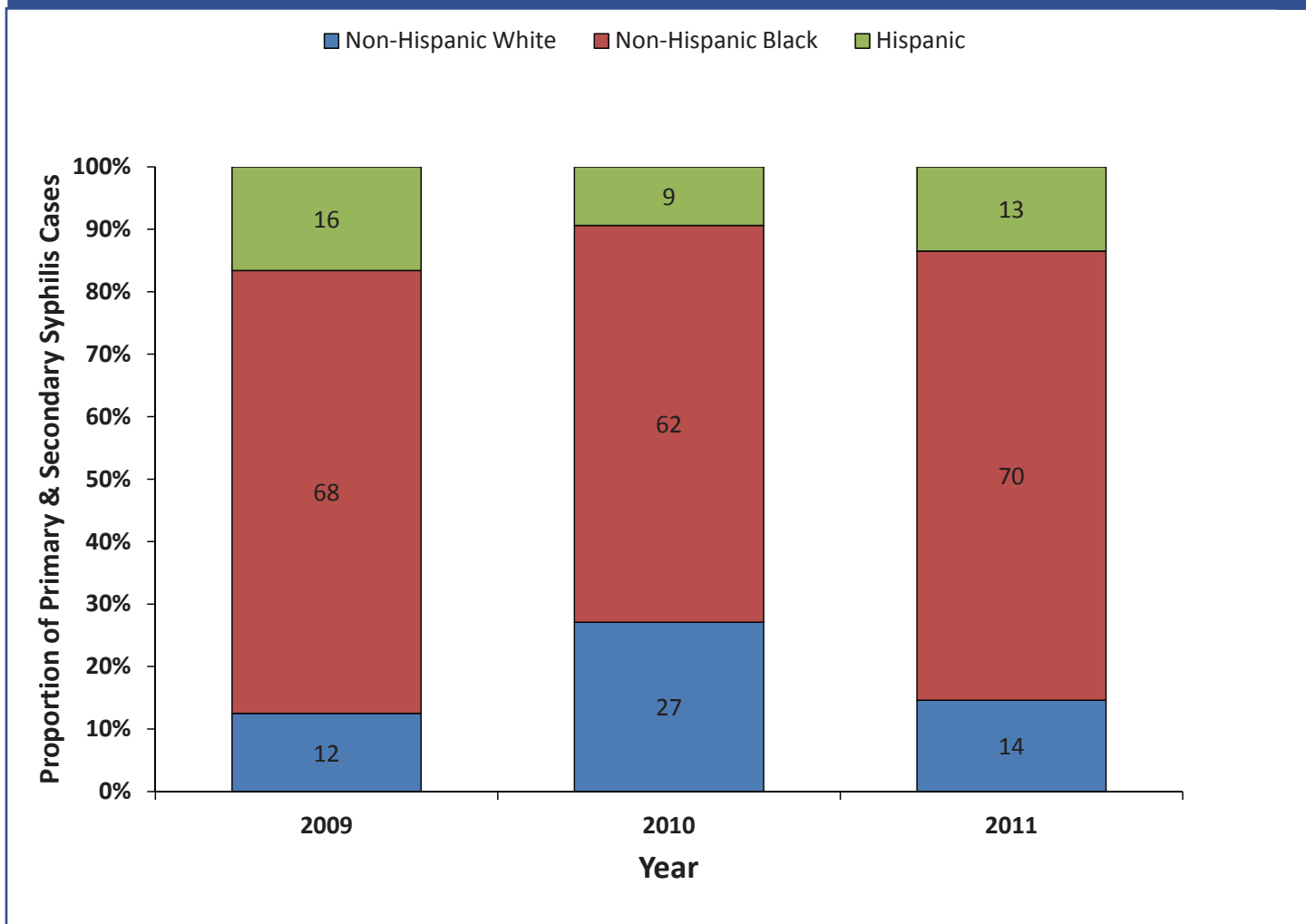
* Incidence rates calculated per 100,000 population based on 2010 estimate of the population (U.S. Census Bureau).

¶ Congenital syphilis rates calculated per 100,000 live births (taken from Community Profiles 2003-2005).

§ Rates not calculated for n<5.

► **Table 4. Syphilis Stage:** Between 2009 and 2011, approximately a third of cases were classified as P&S syphilis. **Sex:** Among P&S syphilis cases in 2011, the overwhelming majority of cases were males (91.2%). The P&S syphilis rate in males in 2011 was 7.6 per 100,000 population, greater than the HP2020 goal for males (6.8 per 100,000 population). The P&S syphilis rate in females in 2011 was 0.7, lower than the HP2020 goal of 1.5 per 100,000 population. **Race/Ethnicity:** In 2011, 70.3% of reported P&S syphilis cases were non-Hispanic Black. **District:** Forty-four percent (44%) of all P&S syphilis cases reported living in the South District and 27.5% reported living in the West District. The rate of P&S syphilis in the South District was 8.5 per 100,000, more than double the 2011 average rate in suburban Cook County of 4.0 per 100,000 population.

Figure 13. Proportion of P&S Syphilis Cases by Race/Ethnicity and Year of Report, Suburban Cook County, 2009-2011



▲ **Figure 13.** Among P&S syphilis cases reported in suburban Cook County in 2011, 70% were non-Hispanic Black, 14% were non-Hispanic White and 13% were Hispanic.

Figure 14. Average P&S Syphilis Rates (per 100,000 population by Municipality (Suburban Cook County) and Community Area (Chicago), 2009-2011

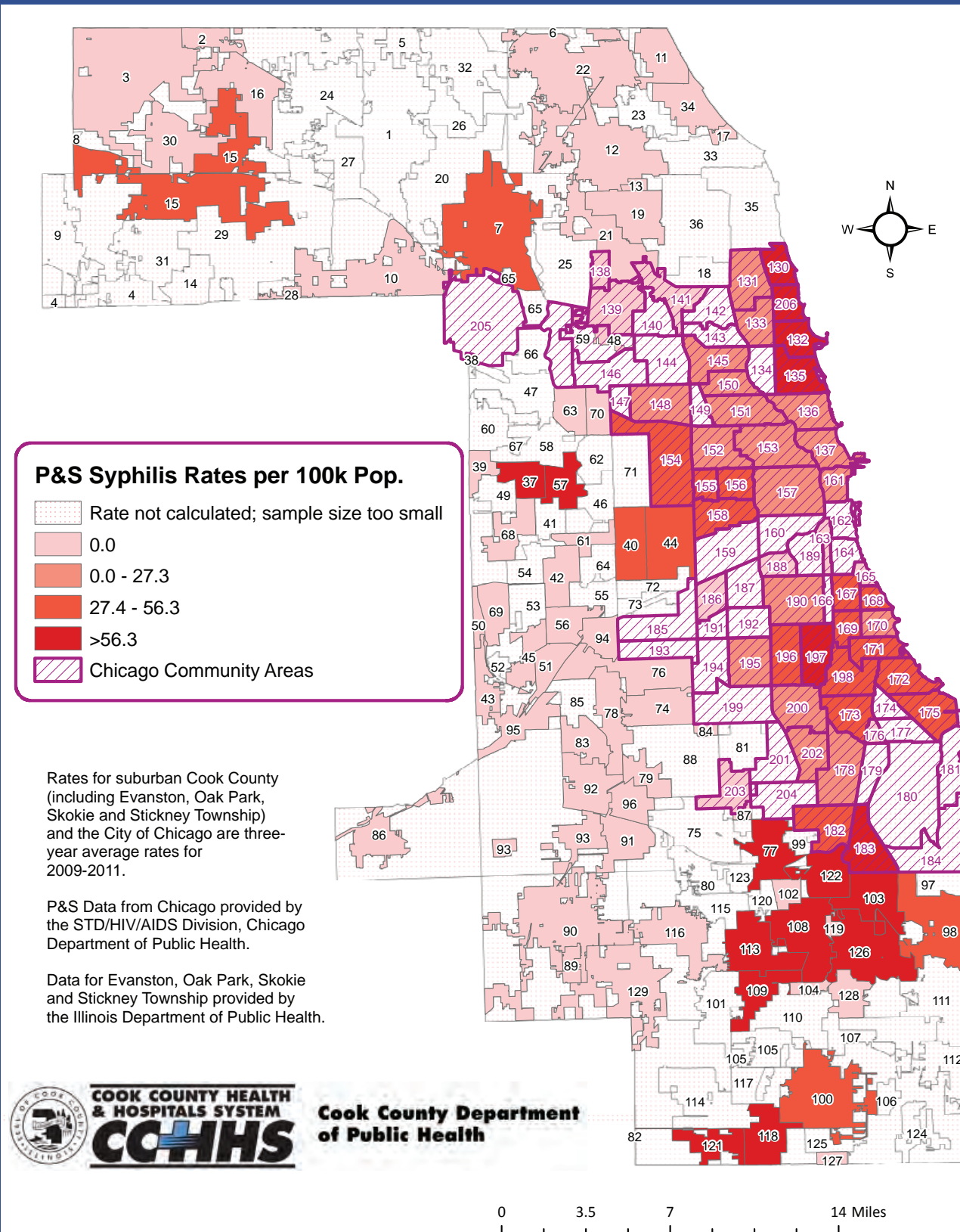


Table 7. Map Key - Suburban Cook County Municipalities and Chicago Community Areas

Ref #	City/Town/Com. Area	Ref #	City/Town/Com. Area	Ref #	City/Town/Com. Area	Ref #	City/Town/Com. Area
1	Arlington Heights	53	La Grange	105	Flossmoor	28	Near West Side
2	Barrington	54	La Grange Park	106	Ford Heights	29	North Lawndale
3	Barrington Hills	55	Lyons	107	Glenwood	30	South Lawndale
4	Bartlett	56	McCook	108	Harvey	31	Lower West Side
5	Buffalo Grove	57	Maywood	109	Hazel Crest	32	Loop
6	Deerfield	58	Melrose Park	110	Homewood	33	Near South Side
7	Des Plaines	59	Norridge	111	Lansing	34	Armour Square
8	East Dundee	60	Northlake	112	Lynwood	35	Douglas
9	Elgin	61	North Riverside	113	Markham	36	Oakland
10	Elk Grove Village	62	River Forest	114	Matteson	37	Fuller Park
11	Glencoe	63	River Grove	115	Midlothian	38	Grand Boulevard
12	Glenview	64	Riverside	116	Oak Forest	39	Kenwood
13	Golf	65	Rosemont	117	Olympia Fields	40	Washington Park
14	Hanover Park	66	Schiller Park	118	Park Forest	41	Hyde Park
15	Hoffman Estates	67	Stone Park	119	Phoenix	42	Woodlawn
16	Inverness	68	Westchester	120	Posen	43	South Shore
17	Kenilworth	69	Western Springs	121	Richton Park	44	Chatham
18	Lincolnwood	70	Elmwood Park	122	Riverdale	45	Avalon Park
19	Morton Grove	71	Oak Park	123	Robbins	46	South Chicago
20	Mount Prospect	72	Stickney	124	Sauk Village	47	Burnside
21	Niles	73	Forest View	125	South Chicago Heights	48	Calumet Heights
22	Northbrook	74	Burbank	126	South Holland	49	Roseland
23	Northfield	75	Alsip	127	Steger	50	Pullman
24	Palatine	76	Bedford Park	128	Thornton	51	South Deering
25	Park Ridge	77	Blue Island	129	Tinley Park	52	East side
26	Prospect Heights	78	Bridgeview	1	Rogers Park	53	West Pullman
27	Rolling Meadows	79	Chicago Ridge	2	West Ridge	54	Riverdale
28	Roselle	80	Crestwood	3	Uptown	55	Hegewisch
29	Schaumburg	81	Evergreen Park	4	Lincoln Square	56	Garfield Ridge
30	South Barrington	82	Frankfort	5	North Center	57	Archer Heights
31	Streamwood	83	Hickory Hills	6	Lake View	58	Brighton Park
32	Wheeling	84	Hometown	7	Lincoln Park	59	Mckinley Park
33	Wilmette	85	Justice	8	Near North Side	60	Bridgeport
34	Winnetka	86	Lemont	9	Edison Park	61	New City
35	Evanston	87	Merrionette Park	10	Norwood Park	62	West Elsdon
36	Skokie	88	Oak Lawn	11	Jefferson Park	63	Gage Park
37	Bellwood	89	Orland Hills	12	Forest Glen	64	Clearing
38	Bensenville	90	Orland Park	13	North Park	65	West Lawn
39	Berkeley	91	Palos Heights	14	Albany Park	66	Chicago Lawn
40	Berwyn	92	Palos Hills	15	Portage Park	67	West Englewood
41	Broadview	93	Palos Park	16	Irving Park	68	Englewood
42	Brookfield	94	Summit	17	Dunning	69	Greater Grand Crossing
43	Burr Ridge	95	Willow Springs	18	Montclare	70	Ashburn
44	Cicero	96	Worth	19	Belmont Cragin	71	Auburn Gresham
45	Countryside	97	Burnham	20	Hermosa	72	Beverly
46	Forest Park	98	Calumet City	21	Avondale	73	Washington Heights
47	Franklin Park	99	Calumet Park	22	Logan Square	74	Mount Greenwood
48	Harwood Heights	100	Chicago Heights	23	Humboldt Park	75	Morgan Park
49	Hillside	101	Country Club Hills	24	West Town	76	O'Hare
50	Hinsdale	102	Dixmoor	25	Austin	77	Edgewater
51	Hodgkins	103	Dolton	26	West Garfield Park		
52	Indian Head Park	104	East Hazel Crest	27	East Garfield Park		

TECHNICAL NOTES

Cook County Department of Public Health Jurisdiction

The jurisdiction of the Cook County Department of Public Health includes all municipalities and portions within Cook County, except for Chicago, Evanston, Oak Park, Skokie and Stickney Township, each of which has its own state-certified local health department. Throughout this report, the term, “suburban Cook County” refers to CCDPH’s jurisdiction with the exceptions noted above.

Data Methodology

Medical providers and laboratories within suburban Cook County are required by law to report positive cases of chlamydia, gonorrhea, and syphilis to the Cook County Department of Public Health within 7 days of diagnosis. These case reports are then entered into a secure database and forwarded to the Illinois Department of Public Health, providing the basis for the information presented in this report. Incidence rates were calculated using population estimates from the U.S. Census Bureau (2010 Census).

Data Limitations

This report includes all reported cases of chlamydia, gonorrhea, and syphilis, but does not represent the entire population of persons infected because not all infected persons have been tested or reported. Frequently, there is a considerable lag between the time a person is diagnosed with an STI and the time the local health department receives the report. Additionally, persons with asymptomatic STIs, such as chlamydia, may be underrepresented in surveillance reports because many such individuals may not seek care, may remain undiagnosed, and, consequently, unreported.